

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State of Dist. of Columbia** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:

Elderly & Persons With Physical Disabilities Waiver Amendment - April 2020

C. Waiver Number:DC.0334

Original Base Waiver Number: DC.0334.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)

04/04/20

Approved Effective Date of Waiver being Amended: 04/04/17

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:



The waiver amendment removes four services; modifies the service delivery provisions for personal care aide (PCA) services and community transition services (CTS); changes the frequency of staff-administered participant/representative employer satisfaction surveys in the participant-directed services program; and edits various performance measures used to assess compliance with the waiver's assurances. Specifically, this waiver amendment proposes the following changes:

(1) Removes the following services from the waiver:

(a) Physical therapy and occupational therapy. Physical therapy and occupational therapy were added in 2015 to ensure that waiver participants could receive these services on a more frequent and continuous basis than offered under the state plan benefit. However, to date, waiver participants have not requested these services in their person-centered service plans, because all participants have sufficient access to physical and occupational therapy under the state plan home health benefit.

(b) Respite services (18-24 hours/day). Daily respite services are currently offered to all waiver participants at two different rates. One rate is for individuals needing between one and seventeen hours per day (1-17 hours/day) and the other rate is for those needing eighteen to twenty-four hours per day (18-24 hours/day). This amendment deletes the provision of 18-24 hours/day respite services, which have not been utilized by waiver participants since November 2015.

(c) Personal Emergency Response System (PERS). This amendment removes the coverage of PERS services from the waiver. Instead, as proposed in a corresponding State Plan Amendment (SPA), PERS will be covered under the state plan Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) benefit. Waiver participants will continue to be eligible for PERS, but as a result of this change, coverage will be extended to those beneficiaries not enrolled in the waiver, but for whom PERS has been determined necessary. A description of proposed updates to the scope of PERS services to be covered under the state plan DMEPOS benefit can be found in the corresponding SPA referenced above.

(2) Limits PCA services for waiver participants to sixteen (16) hours per day. PCA services under the waiver are currently delivered to waiver participants as an extension of the state plan PCA services benefit. State plan PCA services are capped at eight (8) hours per day and PCA services under the waiver are capped at sixteen (16) hours per day; this means that waiver participants can receive up to twenty-four (24) hours of PCA services per day total. This amendment changes the designation of PCA under the waiver from an "extended state plan" service to an "other" service, based on the availability of a delivery modality (participant direction) that is different from what is included under the state plan PCA services benefit. As a result of this change, this amendment limits PCA services for waiver participants to sixteen (16) hours per day. Beneficiaries currently receiving more than sixteen (16) hours per day of PCA services will have no change to the hours of services allotted until otherwise determined by their annual face-to-face reassessment for long term care services and supports.

(3) Removes duplicative reimbursement of PCA hours for beneficiaries residing in Assisted Living Facilities (ALFs). This amendment removes from the PCA service description the provision allowing residents of ALFs to receive additional assistance with activities of daily living through the receipt of the waiver's PCA service.

(4) Changes the frequency of the Services My Way staff-administered survey to once per year. This amendment changes the frequency at which satisfaction surveys are administered to Services My Way participants/ representative employers, from every sixty days (60) days to annually.

(5) Updates the Community Transition Services (CTS) description to:

(a) Clarify that an individual must be successfully enrolled in the waiver prior to the submission of a bill for reimbursement for CTS; and

(b) Reduce the number of days prior to discharge that an individual in a long term care facility is eligible for CTS. Currently, an individual is eligible for CTS individual one-hundred and twenty (120) days prior to discharge from a long term care facility; this amendment changes the period of time that an individual is eligible to sixty (60) days prior to discharge.

(6) Removes the daily cap of sixteen (16) combined hours of PCA services and Adult Day Health Program (ADHP) services for beneficiaries determined eligible for and/or receiving both types of services.

(7) Updates the waiver's quality improvement measures as follows:

(a) Removes duplicative quality improvement measures. In accordance with CMS recommendations, this amendment deletes any duplicate performance measures used to assess compliance with waiver assurances concerning health and welfare, administrative authority, qualified providers, and financial accountability.

(b) Changes a health and welfare performance measure by increasing the period of time within which providers must inform beneficiaries of critical incident investigation outcomes. Currently, providers must inform beneficiaries of such outcomes within twenty-four (24) hours of closure of the investigation; this amendment extends the period of time to five (5) business days from the closure of the investigation.

(8) Removes the 50-bed limit for Assisted Living Facilities (ALFs).

(9) Updates requirements concerning the case loads of case managers. This amendment adds the following two provisions:

(a) The case load for each case manager is limited to no more than forty-five (45) cases total, across all case management agencies, at any given point in time.

(b) The case load for each case manager must be commensurate with his/her number of hours worked per week.

(10) Restricts enrollment in the waiver to those beneficiaries not currently enrolled in another 1915(c) waiver. This amendment clarifies that a beneficiary is not permitted to concurrently participate in multiple 1915(c) HCBS waiver programs. For example, a beneficiary may not be concurrently enrolled--and receiving benefits as a participant--in both the District's EPD waiver and IDD waiver.

(11) Updates the tuberculosis (TB) testing requirements for direct care staff to align with the national standards. This amendment removes the annual TB testing requirement and replaces it with a requirement that TB testing be done in accordance with the guidelines published by the U.S. Centers for Disease Control (CDC).

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	
Appendix A Waiver Administration and Operation	Quality Improvement
Appendix B Participant Access and Eligibility	Quality Improvement
Appendix C Participant Services	C-1; C-1/C-3; Quality Improvement
Appendix D Participant Centered Service Planning and Delivery	Quality Improvement
Appendix E Participant Direction of Services	E-1; E-2
Appendix F Participant Rights	
Appendix G Participant Safeguards	G-1; Quality Improvement: Health & Welfare
Appendix H	H-2
Appendix I Financial	I-2; Quality Improvement

Component of the Approved Waiver	Subsection(s)
Accountability	
Appendix J Cost-Neutrality Demonstration	J-2

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

Modify target group(s)

Modify Medicaid eligibility

Add/delete services

Revise service specifications

Revise provider qualifications

Increase/decrease number of participants

Revise cost neutrality demonstration

Add participant-direction of services

Other

Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The State of Dist. of Columbia requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Elderly & Persons With Physical Disabilities Waiver Amendment - April 2020

C. Type of Request: amendment

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

3 years 5 years

Original Base Waiver Number: DC.0334

Draft ID: DC.003.04.08

D. Type of Waiver (*select only one*):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/03/17

Approved Effective Date of Waiver being Amended: 04/04/17

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (check each that applies):

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)

§1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

PURPOSE:

The HCBS Waiver for the Elderly and Persons with Physical Disabilities (EPD Waiver) serves individuals who are age sixty-five (65) and over, and individuals with physical disabilities who are age eighteen (18) through sixty-four (64) residing in home and community-based settings, including assisted living facilities, in lieu of nursing facilities.

GOAL:

To ensure the EPD Waiver populations (elders and individuals with physical disabilities) have access to in-home supports, including those that are participant-directed, that enable them to reside in their homes while receiving assistance with activities of daily living.

OBJECTIVES:

- (1) Ensure the target populations remain in home and community-based settings that meet all of the requirements of the HCBS regulation under 42 CFR 441.301.
- (2) Ensure the target populations have access to supports that are participant-directed.
- (3) Enhance the quality of life for the target populations by preserving their independence and relationships with family and friends.
- (4) Expand the range of long-term services and supports available for the target populations. Implement a conflict-free case management and person-centered planning delivery process in accordance with the requirements of 42 CFR 441.301.

ORGANIZATIONAL STRUCTURE:

DHCF administers the waiver and its processes.

SERVICE DELIVERY METHODS:

EPD waiver services have defined target populations (elders and individuals with physical disabilities) and specific rules outlining the implementation of services. Provider agencies enrolled by DHCF who serve EPD waiver participants must complete the provider application, meet the waiver service requirements, and have a signed provider agreement with DHCF.

(1) The District of Columbia's Office on Aging, Aging Disability and Resource Center (ADRC) is the first point of contact in the pathway for a DC resident to request long term care services and supports (LTCSS). The ADRC collects general information and demographics and counsels the Applicant on available services. If an Applicant requests long-term care services, an Enrollment Specialist (ES) will be assigned to assist the Applicant with the application process for the EPD Waiver Program.

(2) The ADRC (ES) or its designee will assist the Applicant with obtaining and completing the required paperwork. These include, but may not be limited to, the following documents:

- (a) Physician Authorization
- (b) 30 AW to inform Department of Human Services, Economic Security Administration (ESA) that the applicant is applying for EPD Waiver services
- (c) Rights and Responsibilities
- (d) Freedom of Choice form and Attestation/Case Management Provider Selection Form
- (e) Proof of Residency
- (f) Proof of Income and other supporting financial documentation
- (g) LTC Application

(3) The ES also assists the Applicant request that a level of care (LOC) assessment is conducted by DHCF or its designee (LTCSS Contractor).

(4) DHCF or its designee (LTCSS Contractor) conducts a face-to-face assessment of the Applicant's functional, behavioral, and skilled care needs to determine level of care and determine need for EPD waiver services.

(5) When the LOC is determined via the assessment tool, the ES is responsible for ensuring the information is transmitted to ESA, and ESA is responsible for determining financial eligibility.

(6) ESA performs the financial assessment and makes the determination of financial eligibility.

(7) The disposition of financial assessment is sent to DHCF and ADRC, and eligibility notices are sent to the Applicant or authorized representative.

(8) The ES contacts the selected case management agency (CMA) on behalf of the Applicant and secures acceptance. The ES will contact CMAs until the Applicant is accepted.

(9) DHCF issues a prior authorization to enable the CMA to begin services.

(10) The ADRC transfers the case to the CMA by notifying the CMA of its approval.

(11) The CMA contacts the Applicant and creates a person-centered service plan to identify goals and establish a plan to achieve those goals.

(12) An Applicant may appeal a LOC Denial or EPD Waiver Denial through the Appeals Process.

All EPD waiver participants are afforded the opportunity to self-direct the following services: participant-directed community support (PDCS). Waiver participants who choose to self-direct these services have choice and control over how they are provided and by whom. To assist participants choosing to self-direct these services, a District-wide, IRS-approved Vendor Fiscal/Employer Agent FMS-Support Broker entity provides financial management services (FMS) and information and assistance (I&A) supports as administrative activities. The case manager is also responsible for re-introducing the participant-directed services program to each beneficiary not currently enrolled in the program at the beneficiary's annual renewal and must document that the participant-directed services option was discussed with the beneficiary at that time.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

Yes. This waiver provides participant direction opportunities. *Appendix E is required.*

No. This waiver does not provide participant direction opportunities. *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to

provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

Not Applicable

No

Yes

C. Statewide. Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

Geographic Limitation. A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

Limited Implementation of Participant-Direction. A waiver of statewide requirements is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state. *Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual

might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b)

claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:



The public was requested to provide input on the development of the Waiver. Specifically, case managers, providers, and community advocates are invited to monthly EPD Waiver meetings. Attendees were informed of the renewal process and continued services in the EPD Waiver, along with the separation of case management and direct care services, and asked to share any issues, concerns, and/or recommendations with DHCF/DLTC.

The following information was added pursuant to the Informal Questions period- DHCF shared information regarding the rates or rate methodologies outlined in the EPD Waiver a component of its public comment period. DHCF also shared information on the rate determination methods during the public forum hosted Wednesday, April 29, 2015. The District received no questions during the public comment period, and there were no associated changes made to the proposed rates or rate methodologies.

The following forums/trainings were held to elicit comments in the proposed 2016 Waiver Renewal Application-

- Publication of Public Notice of Proposed Changes in the Renewal Application, published in May 6, 2016 D.C. Register --thirty day (30) day public comment period ran from May 9, 2016 through June 8, 2016
- DHCF held a public forum on June 1, 2016 to review any proposed changes in the Renewal Application
- Copies of this notice and the proposed Waiver Amendment were published on the DHCF website at <http://dhcf.dc.gov>
- Stakeholders had three opportunities to submit comments-
 - o--In-person during the public forum held on June 1, 2016
 - Written comments submitted to the Long Term Care Administration Director
 - Comments were also addressed during the monthly EPD Waiver stakeholder meetings

All written comments were filed, addressed, and documented in an EPD Waiver Renewal Application comment chart, which is available upon request.

Most of the stakeholders' comments were positive and supported the proposed changes in the Application. Some commenters identified issues regarding the delivery of some services under the current waiver and also addressed the EPD waiver application process. Lastly, a few comments were irrelevant because they did not relate to the proposed changes in the Renewal Application and/or critiqued certification processes for aides which are governed by DHCF's sister-agency, the Department of Health.

The comments applauded the addition of Community Transition Services as a new Waiver service and the expansion of the scope of personal care aid service by adding "safety monitoring". It was noted that safety monitoring is an important task needed by many EPD Waiver beneficiaries. Additionally, establishing community transition services to assist residents moving from long-term care facilities was strongly supported by commenters.

A few Stakeholders commented on the streamlining of the renewal process, noting that permitting the case manager to attest the beneficiary continues to meet the nursing facility level of care is a much needed revision. It was conveyed that this new process would be a tremendous benefit to low-income residents with disabilities.

Some of the comments summarized the need to work on overall processes to further streamline and expedite enrollment into the waiver. Some stakeholders noted that the District does not ensure that applications are processed within 60 days from the date of the application. Stakeholders also noted that they believed the delays are due to the policy and practice of DHCF not measuring the 60 day timeline from the date of application, as required by DC law. The District disagrees with this comment and responded by explaining that DHCF works in collaboration with the District's Office on Aging and the Department of Human Services' Economic Security Administration (ESA) to ensure complete applications are processed within the application time period, which is 60 days for applications when the applicant is applying based upon disability and 45 days for all others. DHCF is tracking the amount of time ESA takes to adjudicate completed applications, and DHCF, DCOA, ESA have weekly meetings to discuss and trouble-shoot issues. These efforts have had a positive impact on ESA's processing time, where there is now no backlog of waiver applications and the average processing time is under 45 days.

Stakeholders also noted that there was a need for more training of the Personal Care Aides (PCA) focusing on their scope of duties. DHCF explained that our recent regulations clarified the scope of duties for personal care aides, particularly in regards to not duplicating Homemaker and Chore Aide services. DHCF appreciates a comment about the need for training and clarified in its response that it is working closely with the Department of Health (DOH) to ensure that both agencies are aligned with regards to expectations of the requirements for scope of service, allowable tasks, and training. Lastly, some stakeholders noted there was a need to change the certification requirements for the PCAs, and to ensure that there were pathways for aides to advance in their training and job scope. DHCF explained that although the certification process was led by the Department of Health (DOH), DHCF would share stakeholder input with DOH. There

are no federally recognized tribes in the District of Columbia. Therefore, tribal consultation was not required for this Waiver Renewal Application. The public Input section was updated accordingly to reflect this information.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Gray

First Name:

Ieisha

Title:

Director, Long Term Care Administration

Agency:

Department of Health Care Finance

Address:

441 4th Street NW

Address 2:

Suite 900S

City:

Washington

State:

Dist. of Columbia

Zip:

20001

Phone:

(202) 442-5818

Ext:

TTY

Fax:

(202) 442-8114

E-mail:

Ieisha.Gray@dc.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

	<input type="text" value="NA"/>
First Name:	<input type="text"/>
Title:	<input type="text"/>
Agency:	<input type="text"/>
Address:	<input type="text"/>
Address 2:	<input type="text"/>
City:	<input type="text"/>
State:	<input type="text" value="Dist. of Columbia"/>
Zip:	<input type="text"/>
Phone:	<input type="text"/> Ext: <input type="text"/> TTY
Fax:	<input type="text"/>
E-mail:	<input type="text"/>

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Department of Health Care Finance

Address:

441 4th Street NW

Address 2:

Suite 900S

City:

Washington

State:

Dist. of Columbia

Zip:

20001

Phone:

(202) 442-9075

Ext:

TTY

Fax:

E-mail:

Attachments

melisa.byrd@dc.gov

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

Replacing an approved waiver with this waiver.**Combining waivers.****Splitting one waiver into two waivers.****Eliminating a service.****Adding or decreasing an individual cost limit pertaining to eligibility.****Adding or decreasing limits to a service or a set of services, as specified in Appendix C.****Reducing the unduplicated count of participants (Factor C).****Adding new, or decreasing, a limitation on the number of participants served at any point in time.****Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.****Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

The changes to the current approved waiver proposed in this amendment do not necessitate the implementation of a transition plan.

This amendment removes physical therapy and occupational therapy from the waiver due to a lack of utilization by waiver participants; and PT and OT services will continue to be available to all waiver participants under the state plan home health benefit. Likewise, the removal from the waiver of respite services for 18-24 hours is also due to a lack of utilization by waiver participants. As a result, this change will not result in an actual reduction in services to current waiver participants.

This amendment removes Personal Emergency Response System (PERS) services from the waiver, but DHCF intends to submit a corresponding State Plan Amendment adding PERS coverage (updated to account for recent technological advancements) under the State Plan Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) benefit. Thus, the proposed change to PERS is aimed at expanding access to and coverage of these services.

Finally, under this amendment the personal care aide (PCA) service is no longer an extended state plan service, which has the effect of reducing the total number of PCA hours covered for waiver participants. Under the current approved waiver, participants could be allotted 8 hours of state plan PCA services and another 16 hours of waiver PCA services, for a total of up to 24 hours of PCA per day. This amendment changes the total possible PCA hours per day to 16 hours for waiver participants. Waiver participants who are currently receiving between 17 - 24 hours of PCA services per day will not face an immediate reduction in PCA hours upon approval of this amendment, but will instead continue to receive services in accordance with their person-centered service plan until their annual face-to-face reassessment. Any reduction in PCA hours following the reassessment's determination will be offset by the inclusion of appropriate alternative services in the participant's person-centered plan (e.g., adult day health, PERS, PT/OT, homemaker, chore aide) as determined by the participant, case manager, primary care provider, etc.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

District of Columbia Plan to Comply with New Federal Home and Community Based Services Requirements

Please Note- Due to space limitations, the District is only attaching is a high level summary excerpt from the District of Columbia's Transition Plan submitted to CMS on July 8th, 2016. The District will provide a full copy of the plan upon request.

Section I: Introduction

A. Background on the HCBS Settings Rule

The Centers for Medicare & Medicaid Services (CMS) issued a final rule effective March 17, 2014, that contains a new, outcome-oriented definition of home and community-based services (HCBS) settings. The purpose of the federal regulation, in part, is to ensure that people receive Medicaid HCBS in settings that are integrated in and support full access to the greater community. This includes opportunities to seek employment and work in competitive and integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree as people who do not receive HCBS. CMS expects all states to develop an HCBS transition plan that provides a comprehensive assessment of potential gaps in compliance with the new regulation, as well as strategies, timelines, and milestones for becoming compliant with the rule's requirements. CMS further requires that states seek input from the public in the development of this transition plan.

You can learn about the new rule at www.hcbsadvocacy.org. The website includes links to the CMS rule, webinars, and guidance; information on other states' transition plans; advocacy materials and more. Additionally, a number of national advocacy groups have created a Toolkit that provides advocates with detailed information about the HCBS Settings Rules and provides action steps for advocates to impact implementation of the new rules in their states. The toolkit contains three documents: (1) The Medicaid Home and Community-Based Services Settings Rules: What You Should Know; (2) Home and Community-Based Services Regulations Q&A: Settings Presumed to be Institutional & the Heightened Scrutiny Process, and (3) The Home and Community-Based Settings Rules: How to Advocate for Truly Integrated Community Settings (full and abridged). The toolkit is available at <http://www.aucd.org/docs/policy/HCBS/>.

CMS has updated their Home and Community Based Services (HCBS) website at: www.medicaid.gov/hcbs. If you click the "Statewide Transition Plans" tab, you will see that CMS has added information about their efforts to keep stakeholders apprised of the status of HCBS Statewide Transition Plans (STPs). CMS has also created a "Statewide Transition Plans" page where you will find a chart that has links to the letters that have been sent to states asking for additional information. CMS will continue to provide STP status updates and post communication with states regarding STPs. Please see <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/statewide-transition-plans.html>.

B. Background on the District of Columbia's Statewide Transition Plan

The District of Columbia maintains two HCBS waiver programs: the Elderly and Persons with Disabilities (EPD) Waiver, run by the District's Department of Health Care Finance (DHCF), and the Intellectual and Developmental Disabilities (IDD) waiver, for which the District's Department of Disability Services (DDS) is the operating agency. As noted below, the two waiver programs are very different in size and scope which is reflected in the District's transition plan.

The EPD waiver program is for the elderly and individuals with physical disabilities who are able to safely receive supportive services in a home and community-based setting. There are seven (7) services in the EPD Waiver program, including one residential service, Assisted Living and one day program, Adult Day Health. There are three (3) enrolled Assisted Living providers operating at three (3) sites. As of this update, three (3) additional District-licensed residential service providers operated by the Department of Behavioral Health (two (2) sites) and Department of Health (one (1) site) also provide services to people who are enrolled in the EPD Waiver program. However, these sites are not funded with Medicaid dollars and are not licensed or regulated by DHCF. In keeping with CMS guidance, this transition plan addresses the three (3) EPD waiver residential sites and the three (3) non-EPD Waiver residential sites in which EPD waiver beneficiaries reside operating at the time of the issuance of the federal HCBS Settings rule.

The Adult Day Health Program (ADHP) was added as a State Plan Service in April, 2015 and was added as a waiver service with the last waiver amendment (October 2015), and will be fully implemented under the waiver in Fiscal Year 2017. There currently are six (6) ADHP providers enrolled to deliver services at seven (7) sites. Pursuant to the HCBS rule, the new ADHP sites are not subject to this transition plan. Each site was assessed and determined compliant with the HCBS Settings requirements prior to the provider's enrollment in Medicaid.

The IDD waiver program provides residential, day/vocational and other support services in the community for District residents with intellectual and developmental disabilities. In all, there are twenty-seven (27) services offered through the IDD Waiver. As of this update, there are six hundred thirty-seven (637) sites that are addressed through this plan, five hundred seventy-seven

(577) residential sites, and forty (40) day/vocational sites. The residential sites span Supported Living (475 sites), Host Home (62), and Residential Habilitation (40). The day/vocational twenty-four (24) facility based day habilitation settings are in a facility, and sixteen (16) facility-based employment readiness settings.

Below is the District of Columbia's Statewide Transition Plan for the EPD and IDD HCBS waivers. The District of Columbia timely filed our initial STP with CMS on March 17, 2015, after receiving and responding to extensive public comment. The March 2015 STP is available on-line at: <http://dds.dc.gov/publication/dc-statewide-transition-plan-3-17-2015>. The public comments DHCF and DDS received to the March 2015 STP are available at: <http://dds.dc.gov/publication/public-comments-transition-plan-2-26-2015> and [Insert DHCF link with FINAL draft before 2016 public comment]

In August 2015, DC received a letter from CMS with comments on the March 2015 STP. That letter is on-line at: <http://dds.dc.gov/publication/cms-letter-dc-statewide-transition-plan-8-13-2015> and included items required in this update to the STP.

The District intends to file this update of STP with CMS by September 30, 2016, after a public comment period and an opportunity to receive feedback from CMS. A draft of this update was initially noticed for public comment in the D.C. Register and DDS and DHCF websites on February 12, 2016. The entire plan, including all attachments were posted on the DHCF and DDS websites for public comment on February 19, 2016, with a thirty day public comment period opening on February 20, 2016. Public comments received on the February draft are included below, in Section VIII. The STP has been updated to respond to the public comments received, as well as continuing guidance from CMS. The public notice process for this update to the STP is described in detail below, in Section VII.

The plan and prior iterations are available at <http://dhcf.dc.gov/release/announcement-submitted-cms-district-columbia-plan-comply-new-federal-home-and-community>. For DDS, this plan, along with all prior iterations of the plan, is also available at: <http://dds.dc.gov/page/waiver-amendment-info>. Please see Section VII, Outreach and Engagement, for more information on the District's public comment process.

DHCF and DDS appreciate all of the public feedback we have received, and in particular the ongoing work of the HCBS IDD Settings Advisory Group. If you are interested in participating in that group, please contact Erin Leveton at erin.leveton@dc.gov or (202) 730-1754. Meetings are also posted on the DDS website at <http://dds.dc.gov/> under Upcoming Events. To provide feedback on the EPD Waiver HCBS Settings plan, please contact Ieisha Gray at ieisha.gray@dc.gov or (202) 442-5818.

C. Short Description of the Updated DC Statewide Transition Plan

This Updated DC Statewide Transition Plan is broken into eight sections:

- Section I provides an introduction to the HCBS Settings Rule and this Transition Plan.
- Section II describes the Crosswalk to the HCBS Settings Rule that is used with all HCBS waiver tools and analyses.
- Section III contains information on the total number of DC HCBS Settings by service type and includes our estimate of how many of those settings are currently in compliance with the HCBS Settings Rule; how many can be compliant with modification; and those settings that we find cannot be compliant and will be removed from the waiver program. It includes detailed results of our assessments of provider compliance on a site-by-site basis for HCBS IDD waiver day providers; and in the aggregate, for HCBS IDD waiver residential providers. It also includes detailed results of our assessments of provider compliance on a site-by-site basis for HCBS EPD waiver residential providers, including those that are not Medicaid providers but are delivering residential services to District residents enrolled in the EPD Waiver. Finally, it describes DC's processes for determining whether to submit a provider to CMS for Heightened Scrutiny review.
- Section IV describes key DC initiatives to increase opportunities for people receiving waiver supports to engage in competitive integrated employment and community integration. It includes our approach to employment first activities; a description of training and capacity building activities for providers; and includes links to resources we have developed to support compliance with the HCBS Settings Rule requirements.
- Section V details our process for assessment and remediation. It starts with our state level systemic self-assessment and includes the details of our remediation efforts to date and plans going forward to achieve full compliance with the HCBS Settings Rule by March 17, 2019 for both the IDD and EPD Waivers. It includes a description of the HCBS IDD Waiver Provider Self-Assessments and aggregated results by settings and service types. In this section we describe our process for doing site-by-site assessments of all HCBS IDD waiver day and residential settings and provide aggregate results. We highlight areas of non-compliance for HCBS IDD waiver day providers. It also includes a description of the HCBS EPD Waiver Provider site-by-site assessments, along with aggregate results. (The HCBS EPD Waiver Provider Self-Assessment and monitoring tools are included in Attachments 2-7.) Finally, this section includes a description of how we have used National Core Indicator data to provide a systemic look at compliance across our system of supports for people with intellectual and developmental disabilities.

- Section VI includes our plan to achieve and sustain full compliance with the HCBS Settings Rule. It also states when we will next update this Statewide Transition Plan with information on settings compliance and remediation efforts.
- Section VII includes all public comments received to date on the Updated DC Statewide Transition Plan, as well as links to public comments on earlier versions.
- Section VIII describes our outreach efforts and stakeholder engagement, including the public notice processes that we have used.

Additionally, in accordance with 42 CFR 441.301, all adult day health service providers will meet the “setting requirements”, as verified by the DHCF EPD Waiver Provider Readiness Review process.

These include the following:

- (i) The setting is integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- (ii) The setting is selected by the person from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.
- (iii) Ensures a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- (iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- (v) Facilitates individual choice regarding services and supports, and who provides them.

In addition to the Provider Readiness Reviews, the District will utilize an additional assessment process to ensure that the persons seeking to receive services from the adult day health providers under the EPD waiver are living in settings that comply with the provisions of the HCBS federal regulation. DHCF will use the nurses that conduct face-to-face, conflict-free, standardized assessments of applicants seeking long term care services and supports described under Appendix B (evaluation/revaluation of care) to determine the person’s level of need for services under the waiver. The nurses will also capture additional information to verify and ensure that the person who receives adult day services is living in an environment that comports with the HCBS standards reflected above (441.301 (c)(4)(i-v)) and the additional standards that pertain to provider-owned or controlled residential settings as set forth under 441.301 (c)(4)(vi). Administration of the assessment process during the face-to-face assessments conducted in a person’s residence ensures that the persons accessing adult day services under the EPD waiver live in settings that promote community living.

These include the following:

- (i) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the person receiving services, and the person has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;
- (ii) Each person has privacy in their sleeping or living unit:
 - (1) Units have entrance doors lockable by the person, with only appropriate staff having keys to doors;
 - (2) Persons sharing units have a choice of roommates in that setting; and
 - (3) Persons have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement;
- (iii) Persons have the freedom and support to control their own schedules and activities, and have access to food at any time;
- (iv) Persons are able to have visitors of their choosing at any time;
- (v) The setting is physically accessible to the person; and

(vi) Any modification of the additional conditions specified in §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

- (1) Identify a specific and individualized assessed need;
- (2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan;
- (3) Document less intrusive methods of meeting the need that have been tried but did not work;
- (4) Include a clear description of the condition that is directly proportionate to the specific assessed need;
- (5) Include regular collection and review of data to measure the ongoing effectiveness of the modification;
- (6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
- (7) Include the informed consent of the person; and
- (8) Include an assurance that interventions and supports will cause no harm to the individual.

The State Medicaid agency utilizes various means to ascertain that all waiver settings meet the federal HCB setting requirements. These include the following-

Implementing A Provider Readiness Review Process to Support the HCBS Settings Requirements

To date there are no enrolled ADHP EPD Waiver Providers. However, upon approval of the Waiver, all EPD ADHP providers will be enrolled via DHCF's existing ADHP provider enrollment process. In order for providers to successfully enroll as an ADHP EPD providers, applicants must meet DHCF's Provider Readiness Review process which will ensure that the following are in place: a service delivery plan to render delivery of adult day health services; a staffing and personnel training plan in accordance with any of DHCF's requirements; policies and procedures in accordance with any requirements set by DHCF; and data elements for ensuring compliance with the home and community-based setting requirements in accordance with 42 CFR 441.301

These Data elements ensure that the following requirements, pursuant to 42 CFR 441.301(c) (4) are in place: be chosen by the person receiving services; ensure people's right to privacy, dignity, and respect, and freedom from coercion and restraint; be physically accessible to the person and allow the person access to all common areas; support the person's community integration and inclusion, including relationship-building and maintenance, support for self-determination and self-advocacy, and opportunities for employment and meaningful non-work activities in the community; provide information on individual rights; and allow visitors at any time, with any exception based on the person's assessed need and justified in his or her person-centered plan.

The Entity responsible for verification –DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure provider qualifications. The provider screening and readiness review will include an on-site visit to ensure that the elements of the Provider Readiness Review are in place. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Because ADHP providers must meet the settings requirements immediately, all EPD ADHP providers will similarly meet the settings requirements before providing services.

Implementing Revised State Regulations to Support the HCBS Settings Requirements for Assisted Living facilities

DOH will review licensing applications to ensure that applicants comply with the regulations and HCBS settings requirements as set forth in rule. DOH will require all assisted living licensees be compliant with the HCBS settings rules per the regulations, where the rules must be incorporated into the licensees' policies and procedures, as necessary (including regarding visitation, choice of roommate, and food access and all other requirements of the settings rule). As part of DOH's licensing process, staff conduct an initial visit to inspect the facility's environment. If all is well, DOH will issue the facility a license for 12 months. A 6 months follow-up is required to survey patient care, staffing and the implementation of their policies/procedures.

Revising Provider Requirements

As mentioned above, DHCF's Long Term Care Administration (LTCA) is currently revising its EPD Waiver provider requirements and the application process in order to ensure organizations providing EPD services to DC residents are supporting and facilitating greater individualized community exploration and integration. In addition to reengineering the internal

mechanism for processing provider applications, the LTCA is adopting a new Long Term Care Provider Review Checklist that applicants must use when submitting their application materials. The Checklist will include HCBS Setting requirements and will be posted on DHCF's provider site (www.dc-medicaid.com) by fall 2015. As this checklist is being refined, a section will be added that reflects the HCBS settings rule, where applicants, when appropriate, must attest to complying with the rules and submit their policies and procedures, as appropriate. DHCF will use CMS' "Exploratory Questions to Assist States in Assessment of Residential Settings" to amend the checklist. Only applicants with approved policies and procedures will be referred to DHCF's Division of Public and Private Provider Services for enrollment as EPD waiver providers.

Conducting Statewide Provider Training on New State Standards

Upon publication of the revised existing DOH standards and completion of the revised EPD Waiver provider requirements, DHCF will work with DOH and DCOA's ADRC to co-host no less than three trainings for providers on both the DOH standards and the new EPD provider requirements. DHCF and the ADRC will also co-host a joint training for stakeholders on the DOH standards and the new EPD provider requirements. We anticipate these trainings will begin in the Fall of 2015 and will be publicized via the DHCF website and provider listserv.

Please Note- The State assures that the settings transition plan included within this waiver renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its Waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

DHCF's long term care services and supports contractor determines non-financial eligibility (level of care) by conducting a face-to-face assessment. This assessment utilizes a standardized assessment tool which will include an assessment of the individual's support needs across three domains including: (1) functional; (2) skilled care needs; and (3) cognitive/behavioral.

- 1) Functional - Type and frequency of assistance required with activities of daily living such as bathing, dressing, eating/feeding, transferring, mobility, and toileting.
- 2) Skilled Care Needs - Occurrence and frequency of certain treatments/procedures, skilled care (e.g., wound care, infusions), medical visits, and other types of formal care.
- 3) Cognitive/Behavioral - Presence of and frequency with which certain conditions and behaviors occur (e.g., communication impairments, hallucinations or delusions, physical/verbal behavioral symptoms, eloping or wandering)

The tool also assesses an individual's strengths and preferences, available service, housing options, and availability of unpaid caregiver support to determine the individual's level of need for waiver services and supports.

Completion of the assessment will yield a final total score determined by adding up the individual scores from the three domains. To be eligible for reimbursement of EPD Waiver services, an individual seeking Waiver services has to obtain a score of nine (9) or higher, which is equivalent to a nursing facility level of care.

Each beneficiary shall initially be determined eligible for the waiver based upon the results of a standardized face-to-face, conflict free assessment of functional, behavioral/cognitive, and skilled care needs, conducted by a registered nurse (RN) or licensed independent clinical social worker (LICSW) employed by DHCF or its designated agent. A face-to-face reassessment shall be conducted for each beneficiary at least once every twelve (12) months or upon a significant change in the beneficiary's health status.

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

The waiver is operated by the state Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

The Medical Assistance Unit.

Specify the unit name:

Department of Health Care Finance, Long Term Care Administration (LTCA)

(Do not complete item A-2)

Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*:

DHCF has a MOU with the District of Columbia, Office on Aging, Aging and Disability Resource Center (ADRC). ADRC will provide assistance to EPD Waiver applicants to include the collection of necessary medical and financial information for application processing by DHCF and its contracting agencies.

DHCF's LTCSS contractor determines each applicant/beneficiary's required level of care by conducting a face-to-face assessment of the individual's functional, cognitive/behavioral, and skilled care needs using a standardized needs-based assessment tool for LTCSS. The standardized assessment tool also evaluates an individual's strengths and preferences, available service, housing options, and availability of unpaid caregiver support in determining the assistance required to meet the applicant/beneficiary's needs.

DHCF uses a Vendor Fiscal/Employer Agent (VF/EA) Financial Management Services (FMS) - Support Broker entity to provide financial management and information and assistance services for participants in the Services My Way program.

DHCF utilizes a Quality Improvement Organization (QIO) for some waiver operational and administrative functions. The QIO functions for the EPD Waiver are to prior authorize EPD Waiver services, and perform person-centered individualized service plan reviews to determine if the service plan and the services required are appropriate to meet the needs of the participant and if the services are correctly identified.

No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

DHCF assigns a Contract Administrator (CA) for all contracted entities working on behalf of the District. The CA is responsible for oversight and the assessment of performance of the Contractor.

Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

DHCF provides a multiple-level oversight of the QIO. The various processes are outlined below:

1. The QIO and DHCF hold a monthly Quality meeting to review each contract line item number (CLIN) of the contract. The report provided by the QIO documents the number of reviews requested by provider, percentage of technical denials, percentage of medical necessity denials, percentage of approvals, percentage of timely reviews, and the percentage of untimely reviews. The report includes provider-specific and overall CLIN timeliness. Reconsiderations are a separate CLIN.
2. When the QIO submits their invoice, they include the specific cases that were reviewed and are a part of the invoice. The invoice is not beneficiary or provider specific, but it includes the authorization number- if the services were authorized, and or the episode number if the review was either denied or did not require an authorization.
3. The last report is on the QIO's secure file transfer protocol data sharing site. It is beneficiary specific information for each review performed that month. It includes the beneficiary name, Medicaid ID (MAID), diagnosis, requested service, determination- if a denial was issued the type and reason for the denial.

In its oversight role, the DHCF, Contract Administrator reviews monthly reports developed by the District's Long Term Care Supports Services Contractor. The Contract Administrator reviews the reports and assesses whether there are gaps or trends with performance, and whether the contractor met all requirements identified in the contract. The Contract Administrator also conducts checks of work performed by randomly selecting cases from the contractor database. In addition, DHCF hosts bi-weekly face-to-face meetings with contractor staff (quality improvement manager) to monitor performance. Furthermore, on a daily basis to ensure there is continued communication amongst DHCF and the contractor, there are daily discussions on issues that may arise outside of the routine bi-weekly meetings. DHCF host quarterly meetings with contracted field nurses to ensure that new or revised processes and protocols are discussed with first line staff.

The method used to assess the performance of the VF/EA FMS - Support Broker entity is an annual performance review tool described in detail within the entity's contract, and including a variety of performance measures such as participant and representative satisfaction, results of site visits, reporting mechanisms, and adherence to the VF/EA FMS-Support Broker entity standards incorporated by reference in the contract.

Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than*

one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment		
Waiver enrollment managed against approved limits		
Waiver expenditures managed against approved levels		
Level of care evaluation		
Review of Participant service plans		
Prior authorization of waiver services		
Utilization management		
Qualified provider enrollment		
Execution of Medicaid provider agreements		
Establishment of a statewide rate methodology		
Rules, policies, procedures and information development governing the waiver program		
Quality assurance and quality improvement activities		

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percentage of waiver participants who meet financial eligibility. Total Number of waiver

participants (denominator) Total Number of waiver participants who meet financial eligibility (numerator).

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

FMS reports

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">FMS</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Percentage of actual quarterly waiver expenditures versus projected quarterly expenditures. Projected quarterly expenditures for each waiver service as specified in Appendix J(denominator). Actual quarterly waiver expenditures for each waiver service (numerator)

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: State fiscal intermediary agent	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

Percentage of projected number of EPD waiver slots filled. Numerator = Total number of beneficiaries enrolled in waiver. Denominator = Total number of projected slots for the year.

Data Source (Select one):**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: QIO	Annually	Stratified Describe Group:

	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

Percent of provider records containing completed Medicaid Provider agreements. N = Number of provider records containing completed Medicaid Provider agreements/ D = Number of provider records reviewed.

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>90</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

Performance Measure:

Percent and type (by Assurance) of performance measure indicators in compliance. N = Number of performance measures performing above 86%/ D = Total number of performance measures reviewed.

Data Source (Select one):

Trends, remediation actions proposed / taken

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

DHCF has in place several mechanisms to monitor and analyze EPD waiver performance. The LTCA Oversight and Monitoring Division conducts compliance reviews on performance measures of all waiver assurances. The LTCA Oversight and Monitoring Division is responsible for the discovery and remediation process of individual and systemic issues.

On a monthly basis the Division of Quality and Health Outcomes (DQHO) in concert with the LTCA Oversight and Monitoring Division convenes a Quality Management Committee (QMC). The purpose of QMC is to provide oversight of the EPD program to evaluate the performance and implement quality improvement strategies for continuous quality improvement.

Performance measures are derived from the actual EPD waiver measures approved by CMS or other measures that the program feels are important to monitor. A report card of measures is maintained in the DQHO. The EPD staff submits performance rates to DQHO for tracking and trending. Once performance measure rates are submitted to the DQHO, an analysis is completed on individual performance measures and overall program performance.

The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF.

Additionally, DHCF utilizes a work plan that tracks performance and prioritizes improvement efforts and implementation of the Plan-Do-Check-Act quality improvement process. The work plan will be utilized to formally develop the written quality strategy. This strategy will be in compliance with CMS's national initiatives for home and community based settings. This strategy will be aligned with the National Quality Strategy of better care, healthy people, healthy communities, and affordable care. This program will fit within the Agency's strategic mission and strategic goals.

Task 1. The DQHO partners with the LTCA Monitoring and Oversight Division to conduct a comprehensive program evaluation of the previous EPD waiver program. This evaluation will include an analysis of all components of the EPD waiver. It shall include an iterative process for assessing quality performance, identify opportunities for improvement, and outline recommendations for targeted quality improvement processes and measuring and monitoring of the program's overall effectiveness. This evaluation will be completed by April 2017.

Task 2. The program analysis in addition to the work plan will be used to develop a comprehensive five year quality strategy. The quality strategy will include a process for assessing and revising performance measures at least annually.

Task 3. Provisions will be included to ensure that all applicable providers delivering services to waiver participants shall be subject to quality standards, including but not limited to, guidance issued by the Centers for Medicare and Medicaid Services (CMS) and rules issued by DHCF related to quality improvement activities. All applicable service providers shall be subject to quality standards that adhere to CMS and DHCF guidance related to DHCF's EPD quality strategy, and provide for a continuous Quality Assessment and Performance Improvement (QAPI) program consistent with these requirements. The quality strategy will be completed and implemented by December 2017.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Remediation and fixing individual problems are the responsibility of the State Agency's Division of Long Term Care (DLTC), Elders and Persons with Physical Disabilities Branch (EPPD) and its Manager. EPPD has two approaches for remediation and problem solving. The first of the two approaches focuses on individual beneficiaries and aims to resolve each beneficiary's problems within 24 hours of its presentation. It is not a systematic quality improvement intervention, but an intervention to ensure that foremost a beneficiary is not harmed by the failure of the EPD program to operate in the way in which it is intended.

Such problems are handled by the six (as of 11/5/11) staff who work in EPPD. These staff have access to the state's eligibility and enrollment files, prior authorization records and case management database. They can identify the status of an application, status of a prior authorization request, identity of a case management agency, and these staff intervene quickly to ensure that no harm comes to a beneficiary. These staff document beneficiary complaints and requests for assistance in a tracking log book maintained by EPPD.

When an issue is found to represent a systemic problem (e.g., from data from monitoring visits, beneficiary or provider complaints, findings of the state Agency's Surveillance / Utilization Review (SURS) / Utilization Management unit), a systemic approach is employed. Systemic remediation activity occurs primarily through formal written Medicaid transmittals that identify the systemic problem and the actions that are required to remedy it. These transmittals always include the name of EPPD staff who can answer questions about the problem and its remedy. Also, EPPD holds monthly meetings with waiver providers to review performance-related issues in the aggregate, and provide education, training, and guidance on needed improvements. Finally the Agency's Surveillance / Utilization Review (SURS) / Utilization Management unit also monitors providers compliance with rules governing the EPD waiver program; and recoups payments when there is evidence of noncompliance.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

As mentioned in Question ii (Methods for Discovery), DHCF has in place several mechanisms to monitor and analyze EPD waiver performance. The LTCA Oversight and Monitoring Division conducts compliance reviews on performance measures of all waiver assurances. The LTCA Oversight and Monitoring Division is responsible for the discovery and remediation process of individual and systemic issues.

On a monthly basis the Division of Quality and Health Outcomes (DQHO) in concert with the LTCA Oversight and Monitoring Division convenes a Quality Management Committee (QMC). The purpose of QMC is to provide oversight of the EPD program to evaluate the performance and implement quality improvement strategies for continuous quality improvement.

Performance measures are derived from the actual EPD waiver measures approved by CMS or other measures that the program feels are important to monitor. A report card of measures is maintained in the DQHO. The EPD staff submits performance rates to DQHO for tracking and trending. Once performance measure rates are submitted to the DQHO, an analysis is completed on individual performance measures and overall program performance.

The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF.

Additionally, DHCF utilizes a work plan that tracks performance and prioritizes improvement efforts and implementation of the Plan-Do-Check-Act quality improvement process. The work plan will be utilized to formally develop the written quality strategy. This strategy will be in compliance with CMS's national initiatives for home and community based settings. This strategy will be aligned with the National Quality Strategy of better care, healthy people, healthy communities, and affordable care. This program will fit within the Agency's strategic mission and strategic goals.

Task 1. The DQHO partners with the LTCA Monitoring and Oversight Division to conduct a comprehensive program evaluation of the previous EPD waiver program. This evaluation will include an analysis of all components of the EPD waiver. It shall include an iterative process for assessing quality performance, identify opportunities for improvement, and outline recommendations for targeted quality improvement processes and measuring and monitoring of the program's overall effectiveness. This evaluation will be completed by April 2017.

Task 2. The program analysis in addition to the work plan will be used to develop a comprehensive five year quality strategy. The quality strategy will include a process for assessing and revising performance measures at least annually.

Task 3. Provisions will be included to ensure that all applicable providers delivering services to waiver participants shall be subject to quality standards, including but not limited to, guidance issued by the Centers for Medicare and Medicaid Services (CMS) and rules issued by DHCF related to quality improvement activities. All applicable service providers shall be subject to quality standards that adhere to CMS and DHCF guidance related to DHCF's EPD quality strategy, and provide for a continuous Quality Assessment and Performance Improvement (QAPI) program consistent with these requirements.

The quality strategy will be completed and implemented by December 2017.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

- a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Aged	65		
		Disabled (Physical)	18	64	
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

The group is inclusive of individuals aged 65 and older and individuals aged 18-64 with one or more physical disabilities, who meet at least the functional criteria for admission to a nursing facility ("nursing facility level of care"). Individuals that participate in the EPD waiver must live in a private residence, apartment, or an assisted living facility approved as an EPD waiver provider.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

The maximum age limit for individuals in the waiver's physically disabled target subgroup is 64 years. The minimum age for individuals in the waiver's elderly target subgroup is 65 years, but there is no maximum age limit. Therefore, when an physically disabled waiver beneficiary turns 65, he/she transitions into the waiver's elderly subgroup, which facilitates a continuity of care for the individual.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is *(select one)*

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one):*

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

- c. Participant Safeguards.** When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

- a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	5160
Year 2	

Waiver Year	Unduplicated Number of Participants
	5260
Year 3	5360
Year 4	5460
Year 5	5560

- b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: (*select one*) :

The state does not limit the number of participants that it serves at any point in time during a waiver year.

The state limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	4639
Year 2	4763
Year 3	4888
Year 4	5015
Year 5	5143

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

- c. Reserved Waiver Capacity.** The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes	
Enrollees aging out of HSCSN enrollment	
Community Transitions of institutionalized persons	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (*provide a title or short description to use for lookup*):

Enrollees aging out of HSCSN enrollment

Purpose *(describe):*

To ensure continuation of care for this target group of young adults with special needs.

Describe how the amount of reserved capacity was determined:

The DHCF Division of Research and Rate Setting Analysis, currently called the Division of Rate Setting and Analysis, within the Health Care Policy and Research Administration, ran a report of all beneficiaries in the EPD waiver between ages 22-30 to gauge an approximate number of participants in this waiver to help determine projections for the next five (5) years for this target group. The results yielded a total of 145 individuals with 853/853Q program code with eligibility begin dates of January 1, 2006 or later. DHCF also contacted its primary managed care organization, the Health Care for Children with Special Needs (HSCSN), which coordinates and provides comprehensive health services to beneficiaries with special needs from birth through age 26 to get their data of how many young people age-out from their program into the EPD waiver. HSCSNs data gave a projection of an average of five (5) participants each year for the next five (5) years as likely to enroll in the EPD waiver. Given the number of new unduplicated participants that the District has proposed for the new waiver and the report analysis from HSCSN, the District has determined to reserve 50% of the 145 total number of participants with a 853/853Q code; therefore, a total number of 15 slots will be reserved for the above-mentioned target group each of the five years of the waiver.

(c) policies for the reallocation of unused capacity among local/regional non-state entities:

The District does not anticipate unused capacity for this target group because the demand is more than the available supply; however, the District is currently developing policies and procedures to include reallocation of any unused slots for the reserved capacity group to the target group with the most need at the start of the 12th month of the Waiver Year, in the event that there are any unused portions, though very unlikely.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	15
Year 2	15
Year 3	15
Year 4	15
Year 5	15

Appendix B: Participant Access and Eligibility**B-3: Number of Individuals Served (2 of 4)****Purpose** *(provide a title or short description to use for lookup):*

Community Transitions of institutionalized persons

Purpose *(describe):*

The District, as part of its long-term care rebalancing efforts, has implemented initiatives , including the CMS Money Follows the Person (MFP) Demonstration designed to transition individuals from nursing facility and other institutional settings, e.g. hospitals to community-based settings through its Elderly and persons with Physical Disabilities (EPD) Waiver Program.

Although the EPD MFP transitions began later than anticipated in the District of Columbia due to a variety of challenges and delays including meeting federal planning and data reporting requirements, community-level barriers such as lack of affordable and accessible housing and rental vouchers, and local budgetary constraints that prevented the establishment of the infrastructure required to support the program, the District began utilization of the MFP program for the EPD Waiver target population in 2011, and today has transitioned a total of one hundred twenty three (123) District of Columbia residents into the community from nursing facilities . Based on performance in 2015 (35 transitions from nursing facilities to EPD Waiver Services through MFP, and 32 transitions from LTC facilities after a 90+ day stay without the District's transition coordination assistance), the District plans to continue with 60 participants each waiver year to ensure that District residents who are currently in institutions including nursing homes can have a choice of where they live and receive services while the District provides less costly uncompromised care for them in their communities.

Describe how the amount of reserved capacity was determined:

The reserved capacity for each waiver year is consistent with the actual number of transitions from facilities to the EPD Waiver program in the past year as described above.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	60
Year 2	60
Year 3	60
Year 4	60
Year 5	60

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Eligibility criteria consist of the following: 1) Medicaid eligibility with a maximum monthly income of three hundred percent (300%) of Supplemental Security Income (SSI); 2) The individual requires the level of care furnished in a nursing facility under Medicaid; 3) The individual is either age 65 or older, or age 18-64 with one or more physical disabilities; and 4) The individual is not an inpatient of a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities.

As indicated in eligibility, there are reserved capacities set aside for the EPD waiver in the following amounts: 60 beneficiaries for individuals transitioning to the community from institutions MFP and 15 beneficiaries who are aging out of HSCSN enrollment as for EPSDT enrollees or are eligible to enroll in the EPD waiver. Once the reserved capacities are established, there are no additional preferences and waiver participation is allocated on a first-come, first-served basis.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a (*select one*):

§1634 State

SSI Criteria State

209(b) State

2. Miller Trust State.

Indicate whether the state is a Miller Trust State (*select one*):

No

Yes

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

100% of the Federal poverty level (FPL)

% of FPL, which is lower than 100% of FPL.

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.

Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

All individuals in the special home and community-based waiver group under 42 CFR §435.217

Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the state elects to (select one):

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

ii. Allowance for the spouse only (select one):

Not Applicable (see instructions)

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions) *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

The state uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

ii. Allowance for the spouse only (select one):

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family *(select one):*

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions) *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

Specify dollar amount:

If this amount changes, this item will be revised

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

- ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Other*Specify:*

Performance of initial level of care evaluations and annual level of care reevaluations are conducted by the District's Long Term Care Services and Supports (LTCSS) contractor.

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The initial level of care evaluations are performed by a Registered Nurse (RN) or Licensed Independent Clinical Social Worker (LICSW), licensed in the District and hired by/under contract with DHCF or its LTCSS contractor.

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

A Registered Nurse (RN) or Licensed Independent Clinical Social Worker (LICSW) hired by/under contract with DHCF or its LTCSS contractor conduct face-to-face assessments of each applicant/beneficiary to determine if he/she requires a nursing facility level of care. The face-to-face assessment utilizes a standardized assessment tool (interRAI Home Care Assessment System) to evaluate the individual's care and support needs across three domains: (1) functional; (2) skilled care; and (3) cognitive/behavioral.

- (1) **Functional** - Type and frequency of assistance required with activities of daily living such as bathing, dressing, eating/feeding, transferring, mobility, and toileting.
- (2) **Skilled Care Needs** - Occurrence and frequency of certain treatments/procedures, skilled care (e.g., wound care, infusions), medical visits, and other types of formal care.
- (3) **Cognitive/Behavioral** - Presence of and frequency with which certain conditions and behaviors occur (e.g., communication impairments, hallucinations or delusions, physical/verbal behavioral symptoms, eloping or wandering).

The tool also assesses an individual's strengths and preferences, available service, housing options, and availability of unpaid caregiver support to determine the individual's level of need for waiver services and supports.

Completion of the assessment will yield a final total score determined by adding up the individual scores from the three domains. To be eligible for participation in the EPD waiver, an individual must obtain a score of nine (9) or higher to indicate the need for a nursing facility level of care.

Each applicant/beneficiary shall initially be determined eligible for the waiver based upon the results of a standardized face-to-face, conflict free assessment of functional, behavioral/cognitive, and skilled care needs, conducted by a registered nurse (RN) or licensed independent clinical social worker (LICSW) employed by DHCF or its LTCSS contractor. A face-to-face reassessment shall be conducted for each beneficiary at least once every twelve (12) months or upon a significant change in the beneficiary's health status. Requests for reassessments shall be made by the beneficiary's case manager.

Case managers complete an initial evaluation of the beneficiary's current and historical medical, social, and functional status to determine level of need; conduct monthly, face-to-face home visits to monitor ongoing conditions and provide coordination of care; and submit requests for annual face-to-face reassessments of the beneficiary's continued need for EPD waiver services. Case managers also are responsible for reviewing the results of the beneficiary's face-to-face assessment/reassessments, for completing the beneficiary's comprehensive PCP, and also reviewing the comprehensive PCPs on a quarterly and annual basis.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

- f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

INITIAL ASSESSMENT PROCESS

For all persons seeking to enroll in the EPD waiver program, the ADRC or its designee will be assigned to assist the applicant with the application process. Once physician certification is received, the ADRC or its designee is responsible for assisting the applicant with requesting a face-to-face assessment of his/her level of care needs. The face-to-face assessment is conducted by an RN or LICSW employed by DHCF or its LTCSS contractor, using the standardized assessment tool (interRAI Home Care Assessment System). If the assessment determines that an applicant/beneficiary requires a nursing facility level of care, and is therefore meets the functional eligibility criteria for enrollment in the EPD waiver, the ADRC or its designee is responsible for ensuring that the information is transmitted to ESA.

Once determined that the beneficiary meets or continues to meet nursing facility level of care, ESA is responsible for determining whether the applicant is financially eligible. The disposition of ESA's financial eligibility assessment is sent to DHCF and ADRC, at which point eligibility notices are sent to the applicant and/or authorized representative.

The ADRC Enrollment Specialist (ES) or its designee contacts the selected case management agency (CMA) on behalf of the applicant and secures acceptance. The ES or its designee will contact CMAs until the applicant is accepted. After the case is accepted, the case is transferred to the CMA. The CMA subsequently contacts the applicant and creates a person-centered service plan (PCSP) to address the applicant's care and support needs under the EPD Waiver.

REASSESSMENT PROCESS

The reassessment process is the same as the initial assessment process, except that ADRC does not play a role during the reassessment period. At least one hundred and twenty (120) days in advance of the recertification deadline, DHCF's Long Term Care Administration sends a notice to the CMAs to alert them of the recertification due dates.

Case managers complete an initial evaluation of the beneficiary's current and historical medical, social, and functional status to determine level of need; conduct monthly, face-to-face home visits to monitor ongoing conditions and provide coordination of care; and submit requests for annual face-to-face reassessments of the beneficiary's continued need for EPD waiver services. Case managers also are responsible for reviewing the results of the beneficiary's face-to-face assessment/reassessments, for completing the beneficiary's comprehensive PCP, and also reviewing the PCP on a quarterly and annual basis.

Similar to the initial assessment process, ESA sends the disposition of its financial eligibility reassessment to DHCF and ADRC, mails the eligibility notice to the EPD waiver beneficiary and/or authorized representative, and notifies the CMA and service provider(s) via the electronic case management system. The CMA's case manager contacts the beneficiary enrolled in the waiver and ensures that any necessary modifications to his/her person-centered service plan are made during the beneficiary's annual PCP meeting.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (*specify*):

ESA is responsible for determining the financial eligibility of those beneficiaries determined to require a nursing facility level of care based on their annual reassessment, conducted by an RN or LICSW employed by DHCF or its LTCSS contractor, using the standardized face-to-face assessment tool.

Similar to the initial evaluation process, the disposition of financial assessment is sent to DHCF and ADRC, and ESA then mails the EPD Waiver Approval Notice to the beneficiary enrolled in the EPD Waiver or authorized representative, and the CMA and DHCF are notified via the electronic case management system. The CMA's CM contacts the beneficiary enrolled in the Waiver, and ensures that any modifications are made to the person-centered service plan during the beneficiary's annual PCP meeting.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The records of evaluations and re-evaluations of level of care are stored in the Medicaid electronic case management system, which is maintained by the Medicaid agency (DHCF) at its central office.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

- a. **Sub-assurance:** *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percentage of new enrollees who have a level of care indicating need of nursing home care before receiving waiver services. Total Number of new enrollees (denominator). Number of new enrollees who have a level of care indicating need of nursing home care before receiving waiver services (numerator).

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports generated by QIO

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px;">QIO</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- b. Sub-assurance:** *The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- c. Sub-assurance:** *The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percent of beneficiaries' initial LOC determination made in accord with written policies and procedures established for the contractor by the state Agency. Number of initial LOC determinations completed (denominator). Number of beneficiaries' initial LOC determination made in accord with written policies and procedures established for the contractor by the state Agency (numerator).

Data Source (Select one):

Other

If 'Other' is selected, specify:

Casenet

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify:

		Convenience sample consisting of 30 enrollees chosen at random using an automated random selection program
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

DHCF has in place several mechanisms to monitor and analyze EPD waiver performance. The Long Term Care Administration (LTCA) Oversight and Monitoring Division conduct compliance reviews on performance measures of all waiver assurances. The LTCA Oversight and Monitoring Division is responsible for the discovery and remediation process of individual and systemic issues.

On a monthly basis the Division of Quality and Health Outcomes (DQHO) in concert with the LTCA Oversight and Monitoring Division convenes a Quality Management Committee (QMC). The purpose of QMC is to provide oversight of the EPD program to evaluate the performance and implement quality improvement strategies for continuous quality improvement.

Performance measures are derived from the actual EPD waiver measures approved by CMS or other measures that the program feels are important to monitor. A report card of measures is maintained in the DQHO. The EPD staff submits performance rates to DQHO for tracking and trending. Once rates are submitted to the DQHO, an analysis is completed on individual and overall program performance.

The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF.

Additionally, DHCF utilizes a work plan that tracks performance and prioritizes improvement efforts and implementation of the Plan-Do-Check-Act quality improvement process. The work plan will be utilized to formally develop the written quality strategy. This strategy will be in compliance with CMS's national initiatives for home and community based settings. This strategy will be aligned with the National Quality Strategy of better care, healthy people, healthy communities, and affordable care. This program will fit within the Agency's strategic mission and strategic goals.

Task 1. The DQHO partners with the LTCA Monitoring and Oversight Division to conduct a comprehensive program analysis of the previous EPD waiver program. This evaluation will include an analysis of all components of the EPD waiver. It shall include an iterative process for assessing quality performance, identify opportunities for improvement, and outline recommendations for targeted quality improvement processes and measuring and monitoring of the program's overall effectiveness. This evaluation will be completed by April 2017.

Task 2. The program analysis in addition to the work plan will be used to develop a comprehensive five year quality strategy. The quality strategy will include a process for assessing and revising performance measures at least annually.

Task 3. Provisions will be included to ensure that all applicable providers delivering services to waiver participants shall be subject to quality standards, including but not limited to, guidance issued by the Centers for Medicare and Medicaid Services (CMS) and rules issued by DHCF related to quality improvement activities. All applicable service providers shall be subject to quality standards that adhere to CMS and DHCF guidance related to DHCF's EPD quality strategy, and provide for a continuous Quality Assessment and Performance Improvement (QAPI) program consistent with these requirements.

The quality strategy will be completed and implemented by December 2017.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Remediation and fixing individual problems are the responsibility of the State Agency's Division of Long Term Care (DLTC), Elders and Persons with Physical Disabilities Branch (EPPD) and its Manager. EPPD has two approaches for remediation and problem solving. The first of the two approaches focuses on individual beneficiaries and aims to resolve each beneficiary's problems within 24 hours of its presentation. It is not a systematic quality improvement intervention, but an intervention to ensure that foremost a beneficiary is not harmed by the failure of the EPD program to operate in the way in which it is intended.

Such problems are handled by the six (as of 11/5/11) staff who work in EPD. These staff have access to the Districts eligibility and enrollment files, and MMISadjunct database on EPD Waiver enrollment and case management. They can identify the status of an application, whether or not a LOC determination has been made, the result of the LOC evaluation, and these staff intervene quickly to respond to issues related to LOC determinations. These staff document beneficiary complaints and requests for assistance in a tracking log book maintained by EPPD.

When a systemic problem is found related to LOC determinations, a systemic approach is employed. With respect to LOC determination, these will occur through meetings with the LOC contractor and revisions, as needed, of the written policies and procedures for making LOC determinations.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The District's DQHO has a Program Analyst dedicated to the LTCA and the EPD waiver. This Program Analyst has assisted in development and implementation of an EPD work plan to ensure that all elements of the waiver are in compliance. The Analyst also chairs a Quality Management Committee meeting on a monthly basis that implements the Quality Strategy outline in Appendix H including a Continuous Quality Improvement plan. This process includes the development of Quality Improvement Projects for any assurance that is performing below 86%. All performance measure indicators are in compliance and performing above 95% compliance. The District feels this demonstrates interventions that changed the enrollment process has improved the compliance with its policies and procedures for LOC determinations.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DHCF and sister agencies provide individuals with information about the waiver and also provide them with a provider agency directory listing all qualified provider agencies for case management and direct-care services. Upon choosing a case management provider agency, the ADRC conducts an assessment for participation in the waiver. During the assessment, the individual is offered a choice of either institutional or home and community-based services or eligible individuals are provided with the Waiver Beneficiary Freedom of Choice Form, which they are required to sign.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies of the Beneficiary Freedom of Choice forms are maintained in DHCFs Electronic Case Management System (Casenet).

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The contractual agencies are responsible for obtaining interpretation services

In accordance with District rulemaking, each provider of Waiver services shall establish a plan to adequately provide services to non English speaking participants. The provider shall identify the necessary resources and individuals in order to implement the plan. Identification of necessary resources may include referring the recipient to another services provider agency or businesses with staff that is able to meet the particular language needs of the recipient.

DHCF also has an established language interpreter service.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Adult Day Health		
Statutory Service	Case Management		
Statutory Service	Homemaker		
Statutory Service	Respite		
Other Service	Assisted Living		
Other Service	Chore Aide		
Other Service	Community Transition Services		
Other Service	Environment Accessibility and Adaptation Services		
Other Service	Individual Directed Goods and Services		
Other Service	Participant-Directed Community Support Services		
Other Service	Personal Care Aide		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Service:

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Adult day health services are designed to encourage adults enrolled in the EPD waiver to live in the community by offering non-residential medical supports and supervised, therapeutic activities in an integrated community setting, to foster opportunities for community inclusion, and to deter more costly facility-based care.

Adult day health services includes the following services: medical and nursing consultation services including health counseling to improve/maintain the health, safety and psycho-social needs of persons enrolled in the waiver; individual and group therapeutic activities, including social, recreational and educational activities provided by licensed therapists such as an occupational or physical therapist, and speech language pathologist; social service supports provided by a social service professional including consultations to determine the person's need for services, offering guidance through counseling and teaching on matters related to the person's health, safety, and general welfare; direct care supports services to provide direct supports like personal care assistance, offering guidance in performing self-care and activities of daily living, instruction on accident prevention and the use of special aides; and medication administration services provided by a Registered Nurse (RN) including administration of medication and/or assistance in self administration of medication as appropriate. Persons enrolled in the waiver will also have the option of receiving nutrition and meal services consisting of nutritional education, training, and counseling to persons enrolled and their families, and provision of meals and snacks while in attendance at the day setting. All services will be offered under the person's individualized service plan and be tailored in accordance with their unique needs and choices.

Additionally, in accordance with 42 CFR 441.301, all adult day health service providers will meet the "setting requirements", as verified by the DHCF EPD Waiver Provider Readiness Review process, and specified in Attachment # 2 in the Main Section of the Application.

The Adult Day Health service reimbursement does not include transportation costs. Adult Day Health providers are responsible for coordinating transportation to any off-site visits by utilizing the Non-Emergency Medical Transportation (NEMT) Broker, Medical Transportation Management, Inc.(MTM).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- 1) A provider will not be reimbursed for adult day health services if they do not meet the settings requirements under 42 CFR 441.301, as verified by the Provider screening and Readiness Review.
- 2) A provider shall not be reimbursed for adult day health services if the person enrolled in the waiver is concurrently receiving any of the following services:
 - (a) Day Habilitation or Individualized Day Supports under the 1915 (c) Waiver for Individuals with Intellectual and Developmental Disabilities (ID/DD);
 - (b) Intensive day treatment or day treatment mental health rehabilitative services (MHRS) under the District of Columbia State Plan for Medical Assistance (State Plan);
 - (c) Personal Care Aide services; (State Plan or 1915 (c) waivers);
 - (d) Services funded by the Older Americans Act of 1965, Title IV, Public Law 89-73, 79 Stat. 218, as amended; Public Law 97-115, 95 Stat. 1595; Public Law 98-459, 98 Stat. 1767; Public Law 100-175; Public Law 100-628, 42 U.S.C. 3031-3037b; Public Law 102-375; Public Law 106-501; or
 - (e) 1915 (i) State Plan Option services under the State Plan.
- 3) Additionally, a provider shall not be reimbursed for adult day health services if the person is receiving intensive day treatment mental health rehabilitation services at the same time, or during a twenty-four (24) period that immediately precedes or follows the receipt of adult day health services to ensure that the person is receiving services in the setting most appropriate to his/her clinical needs.
- 4) Adult day health services shall not be provided for more than five (5) days per week and for more than eight (8) hours per day.
- 5) Adult day health services may be used in combination or on the same day as PCA services, as long as these services are not billed concurrently or during the same time.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Health Provider

Provider Qualifications

License (*specify*):

All professionals providing services within the ADHP shall be licensed in accordance with the District of Columbia's Department of Health's Health Occupations Revisions Act. "Health Occupations Revision General Amendment Act of 2009" as incorporated into Title 3, Chapter 12 of the District of Columbia Official Code.

Certificate (*specify*):

Have a valid certificate of Need (CON) as determined by the District of Columbia State Health Planning and Development Agency.

Other Standard (*specify*):

- (1) Have a Medicaid Provider Agreement with DCHCF to be enrolled as an adult day health provider under the EPD Waiver ;
- (2) Meet DHCF's Provider Readiness Review process which will ensure that the following are in place:
 - (a) A service delivery plan to render delivery of adult day health services;
 - (b) A staffing and personnel training plan in accordance with any of DHCF's requirements;
 - (c) Policies and procedures in accordance with any requirements set by DHCF; and
 - (d) Data elements for ensuring compliance with the home and community-based setting requirements in accordance with 42 CFR 441.301; and
- (3) Providers of adult day health services under the EPD Waiver shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics determined by DHCF.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure compliance with EPD Waiver programmatic requirements. The provider screening and readiness review will include an on-site visit to ensure that the elements of the Provider Readiness Review are in place. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Frequency of Verification:

DHCF's Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-validation process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:**Service:****Alternate Service Title (if any):****HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

The conflict-free case management (CM) service is designed to ensure that the beneficiary in need of long-term care services and supports (LTCSS) has opportunities to engage in community life, control personal resources, seek employment and work in integrated settings while receiving services in the community to the same degree as people who do not receive Medicaid funded services. CM services are provided to individuals who are residing in a community setting or transitioning to a community setting following an institutional stay. Transitional CM services are temporary and are only provided to facilitate a person's transition back to the community if the person is institutionalized; regular CM services are continuously provided during the person's enrollment in the waiver when they are residing in the community. Transitional CM services may be provided for a period not to exceed one hundred and twenty (120) days. Transitional CM services include assistance connecting or re-connecting to community resources and services and discharge planning.

The case manager is responsible for assessment, planning, linkage, monitoring, and advocacy relative to the particular needs of the person, where the resources necessary may be external (e.g., housing and education) or internal (e.g., identifying and developing skills). This includes assisting the person to access and maintain all public benefits to which he/she may be entitled. The case manager's role is to support the person in developing a written comprehensive person-centered plan (PCP) (referred to as person-centered-service plan in 42 District of Columbia Municipal Regulations) for Medicaid and non-Medicaid services (including community resources) that reflects the person's strengths, preferences, community and family supports, personal goals, financial resources, and assessed needs. Based on this plan, the case manager assists the person in accessing a mix of services detailed in the PCP in the most integrated community setting appropriate to his/her needs, and provides ongoing monitoring of the person's use of the LTCSS detailed in the PCP. Additionally, the case manager advocates on the person's behalf within service networks while ensuring the person stays connected to all public benefits for which he/she is eligible.

I. Requirements for Person Centered Planning

The case manager shall commit to making services fit persons, rather than making persons fit services, and enable a person-centered process, directed by the person with long-term services and support needs, that meets the following requirements:

- (1) Occurs at a time and location that is convenient for the person and any other individuals that person wants included in the planning;
- (2) Includes face-to-face discussions with the person whose plan is being developed, other contributors chosen by the person, and representatives of the person's interdisciplinary team, as possible;
- (3) Incorporates feedback of members of the person's interdisciplinary team and other key individuals;
- (4) Ensures that information shared with the person is aligned to his or her cultural preferences and communicated in a manner that ensures the person and/or his or her representative understands the information. Communication must be consistent with the policies of the US Health and Human Services Office on Minority Health Standards National Standards on Culturally and Linguistically Appropriate Services (CLAS)
<https://www.thinkculturalhealth.hhs.gov/content/clas.asp>. If needed, auxiliary aids and services should be provided;
- (5) Provides meaningful access to persons and/or their representatives with limited English proficiency, including low literacy materials and interpreters;
- (6) Uses a strengths-based approach to identifying the positive attributes of the person, including an assessment of the person's strengths, preferences, and needs;
- (7) Embraces the personal preferences of the individual to develop goals and meet the person's needs;
- (8) Explores employment and housing in integrated settings, where planning is consistent with the individual's goals and preferences, including where the individual resides and who they live with; and
- (9) Ensures that persons under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, have the opportunity to address any concerns related to the person-centered Individual Service Planning process.

II. Development of the Person-Centered Plan (PCP)

The case manager shall ensure that the PCP highlights the person's strengths and that it aligns with the person's quality of life goals, service and support needs, and preferences. Specifically, the PCP must:

- (1) Document the person's strengths and positive attributes at the beginning of the plan;
- (2) Document the goals of the person and/or representative, which tie to the specific amount, duration, and scope of services that will be provided;
- (3) Document the person's preferences related to end of life planning, as appropriate;
- (4) Be in a language and dialect and at the literacy level needed to be understandable for the person and/or his or her representative;
- (5) Specify the other contributors chosen by the person to engage in the PCP and in monitoring the implementation of the PCP;
- (6) Include consideration of and any resulting goals for employment, education and community participation;

- (7) Identify necessary services and supports, to be provided through Medicaid and non-Medicaid services, including supports from the person's family, friends, faith-based entities, recreation centers, or other community resources;
- (8) Prevent duplicative, unnecessary or inappropriate services by identifying only the necessary services chosen by the person;
- (9) Identify the specific persons and/or health care providers and/or other entities providing services and supports;
- (10) Develop, in partnership with the person, a risk mitigation plan (along with a back-up emergency plan); which consider the person's right to assume some level of responsibility for the identified risk and solutions to mitigate them;
- (11) Assure the health and safety of the person;
- (12) Document the following (if a person's needs related to health and safety warrants restrictions on the person's environment):
 - (a) The explicit and individualized assessed safety need;
 - (b) Positive interventions used in the past to address the same or similar safety risk;
 - (c) Explanation of the condition directly related to the specified safety need;
 - (d) Description of plan modifications addressing the safety risk, and the results of routine collection of data measuring the effectiveness of the modification;
 - (e) Documentation that the person and/or representative understands and consents to the proposed modification;
 - (f) Time limit determined to evaluate if safety modification is still necessary or can be terminated; and
 - (g) Assurance that the modification will not cause harm to the person.
- (13) Address components of self-direction if the person has chosen the Services My Way Program;
- (14) Assure the person's needs will be addressed in the case of a District-wide emergency, such as a black-out or District-wide electronic system failure;
- (15) Receive final approval and signature of the completed PCP from those who participated in its planning and development, with mandatory signatures of the person and the case manager.
- (16) All contributors chosen and invited by the person to participate in the PCP process must receive a copy of the completed PCP (or a component of the plan, as determined by the person).

III. Implementing and Monitoring the PCP

The case manager shall work with the person to implement the PCP. Specifically, the case manager shall:

- (1) Assist with initiating services and accessing community supports.
- (2) Coordinate care across the various and multiple services and /or providers connected to the PCP, regardless of source of payment.
- (3) Monitor the person to ensure that needs and preferences are being met and that the person receives services described in the PCP in type, scope, duration, and frequency.
- (4) Review and update the PCP at least every twelve months or when the person's functional needs change, circumstances change, quality of life goals change, or at the person's request.
 - (a) The case manager must respond to personal requests for updates within forty-eight (48) hours, with completion of the update within seven (7) days.
 - (b) The updated PCP must be done via face-to-face discussions with the person whose plan is being developed, other contributors chosen and invited by the person, and representatives of the person's interdisciplinary team.
 - (c) The updated PCP must incorporate feedback of members of the person's interdisciplinary team and other key individuals if and when they are unable to participate in face to face discussions inclusive of the person.
 - (d) The updated PCP must include approval signatures from those who participated in PCP planning and development, with mandatory signatures of the person and the case manager, and be shared with other EPD Waiver providers, with the permission of the person, to facilitate a person's care coordination.
- (5) Ensure the person continues to meet the EPD-required Level of Care (LOC)
 - 1. Review the initial assessment at least every twelve months to determine if a person has had a significant change in health status.
 - 2. If the CM's review reflects a change (i.e., improvement or worsening) in health status, the CM shall note changes, and shall request a LTCSS assessment by DHCF or its designee (via submission of a signed Prescription Order Form from the person's physician or APRN).
 - 3. If there is no change in health status, the CM will attest that the person continues to meet the EPD-required LOC. This attestation must be communicated to ESA as a part of the Medicaid recertification process.
- (6) Assist in obtaining required documents for the initiation of and on-going maintenance of services (e.g., securing physician orders, financial documents etc.), particularly at the time of required renewals and recertification.
 - 1. The application for recertification should be submitted 60 days prior to the Medicaid expiration date.

2. CMs should begin working on the recertification package upon receipt of the required documents from DHCF or its agent, or no later than 90 days prior to the Medicaid expiration date, whichever is earlier.
- (7) Ensure quality of care and service provision, including identification and resolution of problems with providers and services identified in the PCP.
- (8) Provide supportive counseling to the person and family, as appropriate.
- (9) Maintain records to provide supportive documentation of all conflict-free CM services provided. All records must be maintained in a manner consistent with federal and District of Columbia privacy and confidentiality rules.
- (10) Ensure that Medicaid renewals and any required re-certifications are complete before the end of a person's renewal or certification period, including ensuring the person obtains annual level of care redetermination, if appropriate.
- (11) Monitor implementation of PCP via monthly check-ins that are documented in DC's electronic CM system to ensure that persons are receiving services per the plan.
- IV. Conflict Free Requirements
- CMs shall not:
- (1) Be related by blood or marriage to the person, or to any paid caregiver of the person;
- (2) Be financially responsible for the person, or be empowered to make financial or health decisions on the person's behalf;
- (3) Hold financial interest or have a financial relationship, defined under 42 CFR 411.354, in any entity that is paid to provide care for the individual; and
- (4) Be employed or under contract to a provider of a person's other direct program services under the EPD Wavier.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Included in this service unit are the following activities, related to general oversight of the person relative to their PCP:

- (1) Conducting monthly home visits, at minimum, to check on the person and to ensure services are provided in accordance with the PCP;
- (2) Communicating and coordinating with the person whose plan is being developed, other contributors chosen and invited by the person, and representatives of the person's interdisciplinary team, as needed and possible;
- (3) Communicating regularly with service providers as needed (e.g., providers of other EPD waiver services such as Personal Care Aide services and medical professionals such as gerontologists, etc.);
- (4) Coordinating with other involved case managers or care coordinators (i.e., ADRC transition coordinators or lead agency social workers, etc.);
- (5) Documenting all case management activities;
- (6) Conducting functional evaluation and assisting the person to obtain level of care re-determination and Medicaid recertification, as needed;
- (7) Communicating with State agency personnel, as needed; and
- (8) Any other activities related to the efficient administration of the PCP.

The following limits are applicable to billing-

(1) For transitional case management services provided during a person's institutional stay, billing for those services may occur only after the person returns to the community setting (not during the person's institutional stay). Billing shall be contingent upon demonstration of activities that occurred during the person's institutional stay to facilitate transition to the community such as discharge planning, and assistance in accessing community resources.

(2) The person and/or authorized representatives may elect to receive or not receive any waiver services by signing the "Beneficiary Freedom of Choice Form."

(3) Note that service providers

- May not receive Medicaid reimbursement for case management services to persons who are not Medicaid beneficiaries ; and
- May not provide medical, financial, or legal services (except for referral to qualified individuals, agencies or program).

(4) EPD beneficiaries who are eligible for and elect for enrollment in a Health Home will receive all of their case management services through that HH. HHs that elect to serve EPD beneficiaries will have gone through the EPD provider enrollment process, and will adhere to case management requirements outlined in the EPD waiver. HHs providing case management to EPD beneficiaries will ONLY be able to bill for HH case management (and will NOT be able to bill for EPD case management services).

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service**Service Name: Case Management**

Provider Category:

Agency

Provider Type:

Case Management Agency

Provider Qualifications**License** (*specify*):

Case management agencies are required to be enrolled as a provider in the District of Columbia Medicaid Program as case management agencies in the EPD waiver. Staff providing conflict-free case management services must have current appropriate licensure (Nursing, Social Work, Psychology, Counseling or Therapies), and have a Masters and one year of experience with the population, with either a degree in Social work, Psychology, Counseling, Rehabilitation, Nursing, Gerontology, sociology, or Therapy (OT, PT, Or Speech), OR a Bachelors degree and the above current licensure and 2 years of experience with the population OR Registered Nurse [RN] can have an Associate Degree and 3 years of experience.

Certificate (*specify*):

N/A

Other Standard (*specify*):

Social Service Agency and Community-Based Organization: By-laws or similar documents regulating conduct of providers' internal affairs; policies and procedure and Quality Assurance Plan

Minimum standards

1. Each case manager must be an employee of a social service agency and/or other community-based organization hereafter known as the provider, enrolled as a Medicaid provider. Each case manager must perform case management duties either on a full-time basis (i.e., an employee working 0.75 FTE or greater) or on a part-time basis (i.e., an employee working from 0.5 to 0.74 FTE).
2. Each case manager must display accessibility (e.g., to individuals receiving EPD services; to District staff or designees; and to case management agencies, etc.) by acknowledging and responding to inquiries within 24 hours of receipt.
3. Each case manager must self-attest to meeting the CMS conflict-free standards in accordance with 42 CFR § 441.301 (c)(1)(vi), using the DHCF Conflict-Free Case Management Self-Attestation Form.
4. Each case manager will be assigned to no more than 45 individuals/cases total, across all case management agencies, at any given point in time. The case load for each case manager must be commensurate with his/her number of hours worked per week.
5. A case manager must not be an employee of a Home Health Agency or other EPD-waiver direct service provider.
6. Each case manager must demonstrate a service history and current capacity to assist persons in accessing services provided through the District government and/or through community services.
7. Each case management agency must demonstrate a comprehensive knowledge and understanding of the District of Columbia Medicaid program including knowledge of relevant community resources, limitation on State Plan services, and an understanding of the relationship between State Plan and waiver services where applicable.
8. Each case management agency must establish and implement a process by which the person has been informed of his/her freedom of choice rights, and that the person and/or the person's legal guardian has signed a "Waiver Beneficiary Freedom of Choice Form" indicating that he/she has elected to receive a home and community-based services. Services not provided in accordance with this standard will not be reimbursed.
9. Each case management service provider must provide the person and/or the person's representative, family members and/or legal guardians with agency procedures for protecting confidentiality, for reviewing progress against the PCP, participant rights, and other matters germane to the individual's decision to accept services.
10. Each case manager is responsible for conducting a comprehensive intake assessment of the person within forty-eight (48) hours of receiving the waiver request and prior to the development of the PCP. The intake assessment findings and PCP must be completed within seven (7) working days of conducting the assessment.
11. Each case manager must include other contributors chosen and invited by the person, and representatives of the person's interdisciplinary team, as possible, to participate in the initial assessment and the development and implementation of the approved PCP, as per participant request and/or as appropriate.
12. Development of the PCP must include the person whose plan is being developed, other contributors chosen and invited by the person, and representatives of the person's interdisciplinary team, as possible.
13. It is the responsibility of the case manager to ensure the PCP is provided to the State Agency (or its designee) for approval of services recommended in the PCP. The State Agency (or its designee) will approve or disapprove the services recommended in the PCP within seven (7) working days of its receipt.
14. Each case manager must complete and provide to each case management agency for whom he or she works the DHCF Conflict-Free Case management Self-Attestation form.
15. Each case manager must ensure the person is given the choice to participate in the PDS program and/or offered the free choice of all qualified Medicaid providers of each service included in his/her written PCP.
16. Each case manager must provide the person, the person's representative, family members and/or legal guardians with information on how other needed services (e.g., Medicare, SSI, transit, housing, legal assistance, energy assistance, etc.) may be obtained.
17. All case managers must demonstrate comprehensive knowledge of and actual experience with

assisting persons to access all types of community-based programs including legal services, rent assistance programs, food and nutrition programs (including Supplemental Nutrition Assistance Program/SNAP), cash benefit programs (including SSI) and energy assistance programs.

18. As part of on-going monitoring of the person's PCP, each case manager is required to make an in-home visit to the person at a minimum of at least once per month and more frequently as required by the person's needs. Supplemental telephone contacts may be made as required by the individual needs of the person receiving services.

19. Case managers must provide services in accordance with provider guidelines and any amendments developed by the State Agency.

20. Each case manager is required to assist the person in accessing all necessary services noted in the PCP, whether they are Medicaid (State Plan) services, Medicaid (Waiver) services and/or non-Medicaid financed services.

21. Each case manager is required to take training by the State Agency (as scheduled and required by the State Agency) in order to promote the efficient and effective delivery of Medicaid-financed services.

22. Each case manager must develop and implement a plan to ensure against duplication of services being provided to the person; and

23. Each case manager must administer a Health Status Evaluation Attestation at least annually to determine if there was a significant change in health condition.

2) EPD Waiver Case managers shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF prior to providing case management services.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure compliance with programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services. District of Columbia, Department of Health, Health Regulation, and Licensing Administration is also responsible for verification of license.

Frequency of Verification:

DHCF's Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-validation process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:****Sub-Category 1:**☐**Category 2:****Sub-Category 2:**☐**Category 3:****Sub-Category 3:**☐**Service Definition (Scope):****Category 4:****Sub-Category 4:**☐

Services consisting of general household activities (food preparation and storage, and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent and/or unable to manage the home and/or care for him or herself and/or others in the home. These services do not need to be supervised by a RN.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- 1) Homemaker services may be provided only in cases where neither the individual nor anyone else in the household is able to provide the service or pay for the provision of the service.
- 2) An individual or family member other than the person's spouse, parent of a minor child, any other legally responsible relative, or court-appointed guardian may provide homemaker services. Legally responsible relatives do not include parents of an adult child, so parents of an adult child enrolled in the waiver are not precluded from providing Homemaker services.

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by (check each that applies):****Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed provider of housekeeping services
Agency	Home Care Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Homemaker****Provider Category:**

Agency

Provider Type:

Licensed provider of housekeeping services

Provider Qualifications**License** (*specify*):

Have a general business license issued by the Department of Consumer and Regulatory Affairs to perform housekeeping services in the District of Columbia.

Certificate (*specify*):

N/A

Other Standard (*specify*):

Agencies/Providers must -

- 1) Be enrolled as an EPD Waiver Provider of Homemaker services;
- 2) Have a current Medicaid provider agreement on file with the DHCF before providing any waiver services; and
- 3) Providers must have bylaws or similar documents regulating conduct consistent with waiver and regulatory requirements.

Individual Homemaker standards:

- 1) Be at least 18 years of age;
- 2) Be able to successfully communicate with the person receiving EPD Waiver services;
- 3) Each person providing homemaker services shall complete the annual training requirements for homemakers as specified in this section;
- 4) Maintain an updated CPR certificate; and
- 5) Pass a criminal background check.

If person providing housekeeping services is employed by a business licensed to perform housekeeping services, obtain a minimum of eight (8) hours of training annually in the following areas:

- a. Residents rights;
- b. Communicating effectively with persons enrolled in the waiver;
- c. Preventing Abuse, Neglect and Exploitation;
- d. Controlling the spread of disease and infection;
- e. Changing linens and bed bug prevention;
- f. Food preparation, handling, and storage;
- g. Safe handling of cleaning chemicals (use of gloves, goggles/masks);
- h. Handling hazardous waste;
- i. Blood-borne pathogens and bodily fluids; and
- j. Instructions on the following-
 - i. Dusting
 - ii. Maintenance of floors (mopping/vacuuming)
 - iii. Laundry and safe use of detergents
 - iv. Trash handling
 - v. Cleaning Walls and ceiling
 - vi. Kitchen/Bathroom cleaning/maintenance

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCF's Long Term Care Administration will conduct an initial provider screening and provider readiness review to ensure compliance with EPD Waiver programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Frequency of Verification:

DHCF's Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service**Service Type: Statutory Service****Service Name: Homemaker****Provider Category:**

Agency

Provider Type:

Home Care Agency

Provider Qualifications**License** (*specify*):

Be a home care agency licensed pursuant to the requirements for home care agencies as set forth in the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code, §§ 44-501 et seq. (2005 Repl. & 2012 Supp.)), and implementing rules

Certificate (*specify*):

N/A

Other Standard (*specify*):

- 1) If a home care agency enrolled to provide homemaker services, be enrolled as a Medicare home health agency qualified to offer skilled services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 CFR § 484;
- 2) Be enrolled as an EPD Waiver Provider of Homemaker services;
- 3) Have a current Medicaid provider agreement on file with the DHCF before providing any waiver services; and
- 4) Providers must have bylaws or similar documents regulating conduct consistent with waiver and regulatory requirements; and
- 5) Home Care Agencies providing homemaker services under the EPD Waiver shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.

A person providing homemaker services shall meet the following:

- 1) Be at least 18 years of age;
- 2) Be able to successfully communicate with the person receiving EPD Waiver services;
- 3) Each person providing homemaker services shall be certified as a Home Health Aide in accordance with Chapter 93 of Title 17 of the District of Columbia Municipal Regulations or complete the annual training requirements for homemakers specified in this Appendix (see Other standards under Provider Qualifications); ;
- 4) Maintain an updated CPR certificate; and
- 5) Pass a criminal background check

Verification of Provider Qualifications**Entity Responsible for Verification:**

DHCF's Long Term Care Administration will conduct an initial provider screening and provider readiness review to ensure compliance with EPD Waiver programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Frequency of Verification:

DHCF's Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Service:

Alternate Service Title (if any):

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):**Category 4:**

Sub-Category 4:

Services provided to persons enrolled in the waiver who are unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those individuals who normally provide care for the person.

Respite is usually provided in a person's home. However, Federal financial participation is not to be claimed for the cost of room and board except when respite is provided as part of respite care furnished in a facility approved by the State that is not a private residence, including an Assisted Living facility, Medicaid enrolled group home, or other community care residential facility approved by the State that is not a private residence. Respite services may cover the range of activities associated with the Personal Care Aide role or the Homemaker role. These include, but are not limited to the following activities:

- a. Basic personal care such as bathing, grooming, and assistance with toileting or bedpan use;
- b. Assistance with prescribed, self-administered medication;
- c. Meal preparation in accordance with dietary guidelines and other cultural/religious dietary restrictions, and assistance with eating;
- d. Household tasks related to keeping the recipient's living areas in a condition that promotes the recipient's health, comfort, and safety; and
- e. Accompanying the recipient to medically related appointments.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- 1) Respite services shall not include services that require the skills of a licensed professional, including catheter insertion, procedures requiring sterile techniques, and medication administration.
- 2) Respite services shall not include tasks usually performed by chore workers, including cleaning of areas not occupied by the recipient, cleaning laundry for family members of the recipient, and shopping for items not used by the recipient.
- 3) Respite services shall not be provided to persons who have no primary caregiver that is responsible for the provision of the person's care on an ongoing basis. Respite services are only available to beneficiaries who have a live-in, unpaid caregiver (non-PCA). Respite services are available for beneficiaries' unpaid caregivers (non-PCAs) for a maximum of 480 hours per waiver certification period for hours that are not otherwise staffed by a personal care aide. DHCF will make exceptions to provide respite services to beneficiaries whose unpaid primary caregivers are not living with them.
- 4) Respite services are limited to a maximum of seventeen (17) hours per day, and a maximum of four hundred and eighty (480) hours per year. Requests for respite services in excess of the established limits must be approved by DHCF prior to the provision of the services.
- 5) An individual or family member other than a person's spouse, parent of a minor child, any other legally responsible relative, or court-appointed guardian may provide respite services. Legally responsible relatives do not include parents of an adult child, so parents of an adult child enrolled in the waiver are not precluded from providing respite.
- 6) If respite care is provided in a facility other than a person's residence, the facility must meet all the setting requirements under 42 CFR 441.301 and be enrolled as a Medicaid provider of respite services.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Facility enrolled to provide respite services
Agency	Home Care Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Facility enrolled to provide respite services

Provider Qualifications

License (*specify*):

Requisite license as an Assisted Living Facility, community residential facility or group home.

Certificate (*specify*):

Other Standard (*specify*):

The facility must have a reserved number of beds for respite.
Must be enrolled as a respite provider under DHCF's EPD Waiver program.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure compliance with EPD Waiver programmatic requirements.
Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Frequency of Verification:

DHCF's Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements at least annually.
DHCF's Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-validation process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License (*specify*):

Be a home care agency licensed pursuant to the requirements for home care agencies as set forth in the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code, §§ 44-501 et seq. (2005 Repl. & 2012 Supp.)), and implementing rules

Certificate (*specify*):

Staff providing respite care services must be certified as home health aides or a personal care aides in accordance with Chapter B-39 of Title 22-B of the D.C.M.R.

Staff providing respite care must complete twelve hours [12] of continuing education annually.

Other Standard (*specify*):

- 1) Be enrolled as a Medicare home health agency qualified to offer skilled services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 CFR § 484; and
- 2) Have a current Medicaid provider agreement on file with DHCF before providing any waiver services.
- 3) The home care agency must develop and implement an initial intake protocol that assesses the person's respite needs and the appropriate level of care required to meet the person's needs. This initial intake assessment must be conducted by a Registered Nurse (RN) who is: (a) duly licensed to practice in the District of Columbia, and (b) employed by the home care agency. A copy of the initial intake assessment must be on file with the home care agency.
- 4) The initial intake assessment conducted by the RN must: (a) establish a written emergency notification plan for each person receiving respite care services; and (b) document that the emergency notification requirement must be kept on file with the home care agency for a period of at least ten (10) years.
- 5) An individual providing respite services may not leave the home or place of residence of the person during the period of time which respite care is being provided, unless the home care agency that is responsible for providing the services replaces such caregiver prior to the caregiver removing himself from the person's home or primary place of residence.
- 6) Home Care Agencies providing respite services under the EPD Waiver shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure compliance with EPD Waiver programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Frequency of Verification:

DHCF's Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements at least annually.

DHCF's Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-validation process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:



Assisted Living

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Assisted living services are personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to persons enrolled in the waiver who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). Services that are provided by third parties must be coordinated with the assisted living provider.

All activities associated with providing or coordinating personalized assistance through activities of daily living, recreational activities, 24-hour supervision, and provision or coordination of health services and instrumental activities of daily living.

As specified in DHCF's transition plan (see Amendment, Attachment #2, HCBS Transition Plan), DHCF's Long Term Care Administration (LTCA) is adopting a new EPD Provider Readiness Review Checklist, which will be used to process renewals of assisted living providers' status as EPD waiver providers and to verify compliance with the following requirements under 42 CFR 441.301.

Assisted Living providers provide a variety of services including assistance with activities of daily living, housekeeping activities, coordinating social and recreational activities, and coordinating transportation to community-based events. The reimbursement rate for Assisted Living facilities does not include transportation costs.

Assisted Living providers are responsible for coordinating transportation to any off-site visits by utilizing the Non-Emergency Medical Transportation (NEMT) Broker, Medical Transportation Management, Inc. (MTM).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Assisted Living service does not include housing or meals. Payment will not be made for 24-hour skilled care or supervision; room and board; costs of facility maintenance; or upkeep and improvement. DHCF shall not reimburse for PCA services provided to waiver participants residing in assisted living facilities, as the provision of these services is already accounted for in District Medicaid's assisted living reimbursement rate.

A provider will not be reimbursed for assisted living services if they do not meet the setting requirements under 42 CFR 441.301 as verified by the Provider screening and Readiness Review process.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living Facility

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Assisted Living

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications**License** (*specify*):

Facility must be licensed by the District of Columbia Health Regulation and Licensing Administration
--

Staff RN and/or LPN must maintain current State license

Certificate (*specify*):

Copies of current license and certification of staff, Personal Care Aides, Medication Technician, Homemaker

Other Standard (*specify*):

- | |
|---|
| <p>1) Have a Medicaid Provider Agreement and be enrolled as an EPD Waiver Provider;</p> <p>2) Be in compliance with the Assisted Living Resident Regulatory Act of 2000 (DC St. §§ 44-101.01 et seq.), and Chapter 34 of Title -22 B of the DCMR; and</p> <p>3) Assisted Living service Providers shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.</p> |
|---|

Verification of Provider Qualifications**Entity Responsible for Verification:**

DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure compliance with programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services. District of Columbia, Department of Health, Health Regulation and Licensing Administration is also responsible for verification of license.

Frequency of Verification:

- | |
|---|
| <p>1) DHCF's Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements at least annually.</p> <p>2) DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-validation process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.</p> <p>3) DOH verifies upon review and approval of initial license and every year.</p> |
|---|

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Chore Aide

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Chore Aide services consist of heavy household chores to maintain the home in a clean, sanitary, and safe environment, including washing floors, windows, and walls, tacking down loose rugs, and tiles, and moving heavy items of furniture in order to provide for the person's and other individual providers' safe entry and exit. Ideally, the chore aide prepares the home environment to be safe and clean and to facilitate more routine and ongoing homemaker services. This includes heavy house cleaning of the household so as to initially ensure the homemaker can conduct light household cleaning on a more routine basis.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit is a one hour spent performing allowable task(s). Maximum amount of service permitted under the waiver is 32 units (quantity of four, eight-hour days) per person for the five year waiver period. Service shall be limited to thirty two (32) units per person. Reimbursement for chore aide services may not be claimed by providers who provide services in residences where another party is otherwise responsible for the provision of the service, such as group home providers.

Chore aide services are provided only in cases where the person receiving services, anyone else in the household, the person's landlord, nor a third party payor is able or responsible for providing the service under a lease or other agreement.

Chore aide tasks must be performed in accordance with an Individualized Services Plan [ISP]. In the case of rental property and residential facility, the responsibility of the landlord and/or homeowner, pursuant to the lease agreement, [or other applicable laws and regulations] must be examined (by the case manager) prior to the authorization of chore aide services. It is the responsibility of the case manager to ensure that the requisite documents have been reviewed prior to ordering chore aide services under the ISP. DHCF may grant or deny exceptions to the number of units allowed for a person's use of Chore Aide services.

An individual or family member other than the person's spouse, parent of a minor child, any other legally responsible relative, or court-appointed guardian may provide chore aide services. Legally responsible relatives do not include parents of an adult child, so parents of an adult child enrolled in the waiver are not precluded from providing chore aide services.

Service Delivery Method (*check each that applies*):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by** (*check each that applies*):**Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed provider of chore aide services
Agency	Home Care Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Chore Aide****Provider Category:**

Agency

Provider Type:

Licensed provider of chore aide services

Provider Qualifications**License** (*specify*):

Have a general business license issued by the Department of Consumer and Regulatory Affairs to perform housekeeping services in the District of Columbia

Certificate (*specify*):

N/A

Other Standard (*specify*):

- 1) Be enrolled as an EPD waiver Provider of Chore Aide Services; and
- 2) Have a current Medicaid provider agreement on file with DHCF before providing any waiver services; and
- 3) Providers must have bylaws or similar documents regulating conduct and internal affairs via established Policies and Procedures;
- 4) Individual Chore Aide worker standards are as follows:
 - (a) If employed by a home care agency, be certified as a Home Health Aide in accordance with Chapter 93 of Title 17 of the District of Columbia Municipal Regulations; or
 - (b) If employed by a business licensed to perform housekeeping services, obtain a minimum of eight (8) hours of training annually in the following areas:
 1. Residents Rights;
 2. Communicating effectively with persons enrolled in the waiver;
 3. Preventing Abuse, Neglect and Exploitation;
 4. Controlling the spread of disease and infection;
 5. Changing linens and bed bug prevention;
 6. Safe handling of cleaning chemicals (use of gloves, goggles/masks);
 7. Handling hazardous waste;
 8. Blood-borne pathogens and bodily fluids; and
 9. Instructions on the following-
 - a. Maintenance of floors (mopping/vacuuming)
 - b. Trash handling
 - c. Cleaning Walls and ceiling
 - d. Kitchen/Bathroom cleaning/maintenance
- (c) Chore aides must be 18 years of age and pass a criminal background check
- (d) Chore services must include a pre- and post-cleaning inspection of the home by the Home Care Agency, licensed business providing housekeeping services, and documentation indicating that the home environment has been placed in a state of readiness for ongoing, routine housekeeping (i.e homemaker, and/or personal care aide services). Chore services will not be reimbursed by DHCF unless the Long Term Care Administration is provided with pre-and-post-cleaning documentation; and
- and
- 6) Home Care Agencies providing chore aide services under the EPD Waiver shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure compliance with EPD Waiver programmatic requirements . Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Frequency of Verification:

DHCF's Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements at least annually DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service**Service Name: Chore Aide****Provider Category:**

Agency

Provider Type:

Home Care Agency

Provider Qualifications**License (specify):**

Be a home care agency licensed pursuant to the requirements for home care agencies as set forth in the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code, §§ 44-501 et seq. (2005 Repl. & 2012 Supp.)), and implementing rules.

Certificate (specify):

N/A

Other Standard (specify):

- 1) If enrolled as a home care agency, also be enrolled as a Medicare home health agency qualified to offer skilled services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 CFR § 484;
- 2) Be enrolled as an EPD waiver Provider of Chore Aide Services; and
- 3) Have a current Medicaid provider agreement on file with DHCF before providing any waiver services
- 4) Providers must have bylaws or similar documents regulating conduct and internal affairs via established Policies and Procedures
- 5) Individual Chore Aide worker standards are as follows:
 - (a) If employed by a home care agency, be certified as a Home Health Aide in accordance with Chapter 93 of Title 17 of the District of Columbia Municipal Regulations;
 - (b) Chore aides must be 18 years of age and pass a criminal background check
 - (c) Chore services must include a pre- and post-cleaning inspection of the home by the Home Care Agency, and documentation indicating that the home environment has been placed in a state of readiness for ongoing, routine housekeeping (i.e homemaker, and/or personal care aide services). Chore services will not be reimbursed by DHCF unless the Long Term Care Administration is provided with pre-and-post-cleaning documentation.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DHCF Division of Public and Private Provider Services will conduct an initial provider screening to ensure that provider qualifications are met. Additionally, once provider qualifications are verified, DHCF's Long Term Care Administration (LTCA) will conduct a provider readiness review. The provider readiness review will include an unscheduled on-site visit to ensure that the elements of the Provider Readiness Review are in place.

Frequency of Verification:

DHCF's LTCA and DHCF's Division of Public and Private Provider Services will verify provider readiness during initial provider application review process as well as the re-enrollment process. (every three years).

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transition Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institution or other long-term care facility to a more integrated and less restrictive community setting. Allowable expenses are those necessary to enable an individual to establish a basic household that does not constitute room and board and may include:

- (a) application fees and security deposits in the amount of the first month's rent or greater that are required to obtain a lease on an apartment or home;
- (b) essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
- (e) moving expenses;
- (f) necessary home accessibility adaptations; and
- (g) activities to assess need, arrange for and procure needed resources.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the transition planning process, and clearly identified in the individual's transition plan or PCP once they are enrolled in the EPD Waiver.

DHCF or its designee, and Case Managers shall coordinate community transitional supports while an individual is an inpatient in an institution or long-term care facility. Once the individual has enrolled in the EPD Waiver and transitions into the community Case Managers shall coordinate transitional community supports for a period not to exceed six months from the date of discharge into the community. A Financial Management Services Support Broker will be responsible for procuring services and goods on behalf of the individual.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Community Transition Services (CTS) up to an amount of five thousand dollars (\$5,000) may be used as determined in the transition plan development. An individual is eligible for CTS from the time a tentative discharge date has been established for no more than sixty (60) days prior to, and up to six (6) months following, discharge from an institution or long-term care facility. The individual must be enrolled in the waiver prior to the submission of a bill for reimbursement for covered CTS.

Community Transition Services do not include monthly rental or mortgage expenses; food beyond pantry set-up; regular utility charges; household appliances or items that are intended purely for recreational purposes; environmental accessibility adaptations services that are of direct medical or remedial benefit to the person; and/or any durable medical equipment when these services and equipment are covered by a service other than Community Transition Services.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Transition Services

Provider Category:

Agency

Provider Type:

Case Management Agency

Provider Qualifications

License (*specify*):

Any relevant license referenced under the Case Management Service Description in Appendix C

Certificate (*specify*):

N/A

Other Standard (*specify*):

Any relevant standards referenced under the Case Management Service Description in Appendix C

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure compliance with EPD Waiver programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services. District of Columbia, Department of Health, Health Regulation, and Licensing Administration is also responsible for verification of license.

Frequency of Verification:

DHCF's Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-validation process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environment Accessibility and Adaptation Services

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):**Category 4:**

Sub-Category 4:

Those physical adaptations to the private residence of the person or the person's family, required by the person's person-centered individual service plan, that are necessary to ensure the health, welfare and safety of the person seeking EAA services or that enable the person to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars/hand-rails, widening of doorways, installation of lift systems, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the person enrolled in the waiver .

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The maximum allowable cost per person seeking EAA services is \$10,000. This rate is inclusive of a five hundred dollar (\$500) reimbursement rate for the costs associated with the home inspection or evaluation. All service(s) required are subject to approval or denial by the State Agency prior to the provision of such service(s). This is a one-time service limited to \$10,000 per person over the duration of the waiver.

Both certified home-owners, and renters are eligible for EAA services. EAA services will only be approved or reimbursed for a certified home owner who can demonstrate that they are ineligible for the Handicap Accessibility Improvement Program (HAIP) administered by the DC Department of Housing and Community Development. The case manager shall assist all eligible and certified home owners to apply for the HAIP program. If a home owner is denied participation in the program, the person seeking EAA services must provide a copy of the denial letter to the case manager. Renters will be exempt from proving ineligibility for HAIP.

In the case of rental property and/or leased property, no EAA services will be approved or reimbursed unless the following conditions are met: 1) the current rental and/or lease agreement, or residential agreement (and all other relevant documents) are thoroughly examined (by the case manager) to determine whether EAA services are prohibited or allowed with conditions, and (2) a signed release was obtained from the management of the property authorizing the EAA home modifications to be made. Case Managers will only contact landlords with the permission of the person receiving services.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E**Provider managed**

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Third Party Construction Inspector; Licensed Contractor; or Licensed Building Contractor

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Environment Accessibility and Adaptation Services****Provider Category:**

Individual

Provider Type:

Certified Third Party Construction Inspector; Licensed Contractor; or Licensed Building Contractor

Provider Qualifications**License (specify):**

All Contractors shall be licensed by the Department of Consumer and Regulatory Affairs

Certificate (specify):

Certified Third Party Construction Inspector shall be certified under the District of Columbia Department of Consumer and Regulatory Affairs, Third Party Inspector Program

Other Standard (specify):

- 1) All persons must be able to demonstrate to the EPD waiver participant the ability to successfully communicate with them. Individuals and businesses providing services and supports shall have all the necessary licenses required by federal, state and local laws and regulations, IF APPLICABLE.
- 2) Contractors must be enrolled as an EPD Waiver provider.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure compliance with programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Frequency of Verification:

DHCF's Long Term Care Administration will monitor programmatic requirements at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Individual Directed Goods and Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the person-centered Individual Service Plan (ISP) (including improving and maintaining the individual's opportunities for full membership in the community) and meet the following requirements. The item or service would:

- decrease the need for other Medicaid services; and/or
- promote inclusion in the community; and/or
- increase the waiver participant's safety in the home environment.

Individual-directed goods and services are only available to waiver participants who are enrolled in the Services My Way program, which is the participant-directed services (PDS) program in the District of Columbia. Furthermore, individual-directed goods and services are only available if the individual does not have the funds to purchase the good or service or the good or service is not available through another source. Individual-directed goods and services are purchased from the participant's PDS budget. Experimental or prohibited treatments are excluded. Individual-directed goods and services must be documented in the participant's person-centered PCP and approved by the Services My Way Program Coordinator at DHCF.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Waiver participants who elect to enroll in the Services My Way program may purchase individual-directed goods and services that are included in their PCP, meet the criteria listed above and are within the means of their PDS budget to purchase. Support brokers help participants revise their PDS budgets, as necessary, to account for new, appropriate individual-directed goods and services they would like to purchase and help them manage their PDS budgets.

Upon revising a PDS budget to reflect a new individual-directed good or service, the support broker submits the revised PDS budget to the Services My Way Program Coordinator. The Program Coordinator reviews all requested individual-directed goods and services, and either approves or denies the requested item. Upon approval, the Services My Way Program Coordinator will submit the amended PDS budget to the Vendor Fiscal/Employer Agent (VF/EA) Financial Management Services (FMS)-Support Broker entity, allowing the VF/EA FMS-Support Broker entity to authorize payment of vendor invoices submitted for the approved individual-directed goods and services.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual/Vendor as selected by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Individual Directed Goods and Services

Provider Category:

Individual

Provider Type:

Individual/Vendor as selected by the participant

Provider Qualifications

License (*specify*):

Valid Business License in good standing, if applicable

Certificate (*specify*):

N/A

Other Standard (*specify*):

All individuals/vendors providing individual-directed goods and services must be at least eighteen (18) years of age. All individuals/vendors must be able to: (1) demonstrate to the waiver participant that they have the capacity to perform the requested work and the ability to successfully communicate with him/her; and (2) have all necessary professional and/or commercial licenses required by federal, state and local statutes and regulations, if applicable.

Individuals/vendors providing non-medical transportation as an individual-directed service must have: (1) a valid drivers license and (2) the minimum amount of liability insurance required by the District of Columbia for the type of vehicle used to provide the transportation. Furthermore, if applicable, individuals/vendors shall enter into a Medicaid provider agreement, as required by CMS, which shall be executed by the VF/EA FMS-Support Broker entity on behalf of DHCF.

Verification of Provider Qualifications

Entity Responsible for Verification:

VF/EA FMS-Support Broker entity

Frequency of Verification:

At time of enrollment and thereafter as necessary.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Participant-Directed Community Support Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Participant-Directed Community Support (PDCS) is available to waiver participants enrolled in the Services My Way program as described in Appendix E. Services offered under PDCS are detailed in the participant's person-centered Service Plan (PCP) and PDS budget and are designed to promote independence and ensure the health, welfare, and safety of the participant.

The participant or his/her designated representative, as applicable, is the common law employer of the participant-directed worker (PDW) providing services. These PDWs are recruited, selected, hired, and managed by the participant/representative-employer. As described in Appendix E, supports are available to assist the participant/representative-employer with employer-related responsibilities through the VF/EA FMS-Support Broker entity.

Allowable Tasks:

Tasks performed by a PDW include cueing, safety monitoring, and hands-on assistance with activities of daily living, and instrumental activities of daily living.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The tasks performed under PDCS are similar to those performed by a personal care aide (PCA). However, PDCS is provided pursuant to a person's PDS budget and uses a different rate methodology as described in Appendix E. Payment will not be made to a PDW who is the participant's spouse, parent, or, if minor participant, legal guardian.

All PDCS services provided by a PDW must be prior authorized in order to participate in the Services My Way program.

- 1) PDCS services must be included in the participant's PCP, and the participant must be in receipt of a service authorization for EPD Waiver services as established by the receipt of a score of nine (9) or higher on the standardized assessment tool which equates to a nursing home level of care (or higher) including extensive assistance or total dependence with two or more ADLs.
- 2) Payment shall be provided in accordance with the participant's PDS budget and at an hourly wage within the wage range prescribed by DHCF. The hourly wage for a PDW shall be no less than the DC living wage and no more than the hourly wage paid to a PCA. Payment is dictated by the amount, duration, and scope of services determined in accordance with the participant's service authorization pursuant to the face-to-face assessment conducted by DHCF or its agent.
- 3) An individual or family member other than the participant's spouse, a parent of a minor child, any other legally responsible relative, or court-appointed guardian may act as a PDW. Legally responsible relatives may not act as PDWs. Legally responsible relatives do not include parents of an adult child, so parents of an adult child participant are not precluded from providing PDCS services.
- 4) Other limitations on PDCS include the following:
 - a. PDCS shall not include services that require the skills of a licensed professional, such as catheter insertion, procedures requiring the use of sterile techniques, and medication administration.
 - b. PDCS shall not include tasks usually performed by chore workers or homemakers, such as cleaning of areas not occupied by the participant, laundry for family members, shopping for items not used by the participant, or money management.
 - c. PDCS shall not be provided in a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID) or institution for mental disease, or any other living arrangement which includes PCA services as a reimbursed service.
 - d. When a person is receiving PDCS and any adult day services (waiver or State Plan) on the same day, the combination of both PDCS and adult day services shall not exceed a total of sixteen (16) hours per day.

Service Delivery Method *(check each that applies):*

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies):*

Legally Responsible Person**Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Individual	Individual, Participant-Directed Worker

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Participant-Directed Community Support Services****Provider Category:**

Individual

Provider Type:

Individual, Participant-Directed Worker

Provider Qualifications**License** (*specify*):

N/A

Certificate (*specify*):

NA

Other Standard (*specify*):

Participant-directed workers (PDWs) must meet the following qualifications:

- Be at least eighteen (18) years of age;
- Complete and pass a criminal background check pursuant to the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999, as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code §§ 44-551 et seq.);
- Receive customized training provided by the participant and/or his/her authorized representative;
- Be able and willing to provide the service-related responsibilities outlined in the participant's PCP;
- Be certified in cardiopulmonary resuscitation (CPR) and First Aid through an in-person training course approved by the American Red Cross or an alternative course approved by the Services My Way Program Coordinator and maintain current certifications; and
- Not be a participant in the Services My Way program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The participant or authorized representative if designated as the common law employer of PDWs, and the VF/EA FMS-Support Broker entity determining if PDW has met minimum qualifications.

Frequency of Verification:

At time of PDW recruitment prior to hire, and thereafter, once hired, as necessary. The VF/EA FMS-Support Broker entity verifies that PDW qualifications are met during the employment process and executes a Medicaid provider agreement with each PDW on behalf of DHCF.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:



Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Care Aide

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Tasks include cueing, safety monitoring, assistance with activities of daily living and assistance with instrumental activities of daily living. Services involving assistance with one or more activities of daily living that is rendered by a qualified personal care aide (PCA) under the supervision of a registered nurse. The scope, service authorization, and nature of these services do not differ from personal care services furnished under the State plan. The allowable tasks and provider qualifications/certifications specified in the State plan apply. Under the EPD waiver, participant direction is available for PCA services; this delivery modality is not an option offered under the State plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

(1) Limitations do not differ from those established under the Medicaid State plan with the exception of the following:

(a) To be eligible for waiver PCA services, they must be included in the person's PCSP, and the person must be in receipt of a service authorization for EPD waiver services as established by the receipt of a score of nine (9) or higher on the standardized LTCSS face-to-face assessment, which equates to a nursing home level of care (or higher), including the need for extensive assistance or total dependence with two or more ADLs.

(b) Reimbursement for waiver PCA services shall not exceed sixteen (16) hours per day per EPD waiver beneficiary. EPD waiver participants are not eligible to receive State Plan PCA services.

(c) Similar to the State plan, all waiver PCA services related to meal preparation shall be in accordance with the person's dietary guidelines, including low sodium intake guidelines, or other restrictions, and also take into account any cultural/religious dietary preferences in accordance with the PCSP.

(2) Payment shall be provided at an hourly rate established by DHCF. The unit of service is fifteen (15) minutes. Payment will be the reimbursed units determined by the service authorization and billed in accordance with the person-centered plan.

(3) An individual or family member other than the person's spouse, a parent of a minor child, any other legally responsible relative, or court-appointed guardian may provide PCA services. Legally responsible relatives do not include parents of an adult child, so parents of an adult child enrolled in the waiver are not precluded from providing PCA services.

(4) Other limitations include the following:

(a) PCA services shall not include services that require the skills of a licensed professional, such as catheter insertion, procedures requiring the use of sterile techniques, and medication administration.

(b) PCA services shall not include tasks usually performed by chore aides or homemakers, such as cleaning of areas not occupied by the recipient, laundry for family members, shopping for items not used by the recipient, or money management.

(c) PCA services shall not be provided in a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, institution for mental disease, assisted living facility, or any other living arrangement which includes PCA services as a reimbursed service.

(d) A waiver beneficiary may receive PCA and adult day health services (Waiver or State Plan) on the same day, so long as these services are not billed concurrently.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Personal Care Aide

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License (*specify*):

Be a home care agency licensed pursuant to the requirements for home care agencies as set forth in the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code, §§ 44-501 et seq. (2005 Repl. & 2012 Supp.)), and implementing rules; and

Certificate (*specify*):

N/A

Other Standard (*specify*):

- 1) Be enrolled as a Medicare home health agency qualified to offer skilled services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 CFR § 484;
- 2) Have a current Medicaid provider agreement on file with DHCF as an enrolled EPD Waiver provider before providing any waiver services;
- 3) All Personal Care Aides shall have the same qualification and standards as established under the Medicaid State Plan including certification under Chapter 93 of Title 17 of the DCMR; and
- 4) Home Care Agencies providing personal care aide services under the EPD Waiver shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure compliance with EPD Waiver programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Frequency of Verification:

DHCF's Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-validation process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case Management service providers conduct all case management services for waiver participants. Case Management agencies serve as case management service providers and provide case management services on behalf of waiver participants. These services include conducting direct observation of the participant, conducting an initial comprehensive assessment of the participant's medical, social, and functional status to include obtainment of level of care determinations, determining and developing the participant's Person-Centered Service Plan (PCSP), and administering an annual Health Status Evaluation to evaluate if there were any significant change in the participant's health care needs.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

(a) All direct care individuals and providers including personal care aides, attendants, and respite care providers must undergo criminal background checks. Case managers are licensed professionals, who are required to get a criminal background check per the District's licensing laws.

(b) The scope of investigations includes a criminal background check at the District level (state level).

(c) The process for ensuring that mandatory investigations have been conducted is a condition of participation for all Medicaid provider agencies. A representative sample of personnel records are reviewed annually to ensure compliance. As a condition of participation in the Medicaid program, each Home Health Care Agency shall ensure that each direct care provider has passed a criminal background check. Each direct care provider must always pass a criminal background check pursuant to the Health-Care Facility, Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238: D.C. official Code, § 44-551 et seq.). The (District) Metropolitan Police Department is the entity responsible for conducting all criminal background checks for staff of all agencies such as Personal Care Aides (PCAs). The worker (PCA) is responsible for ensuring that the Home Health care agency receives copy of the criminal background check. The home health agency is responsible for verifying that the background check is authentic.

DHCF is responsible for reviewing a sample of all personnel records to ensure that the check is indeed conducted. The District requires that all case managers are licensed health professionals.

Staff providing conflict-free case management services must have a current appropriate licensure as a Health Professional (e.g., Nursing, Social work, Psychology, Counseling, Occupational therapy, Physical Therapy, or Speech Therapy).

As part of obtaining and maintaining a license in the District, all health professionals must undergo a criminal background check at the time of obtaining a license and upon renewal of license pursuant to the "Licensed Health Professional Criminal Background Check Amendment Act of 2006", effective March 6, 2007, (D.C. Law 16-222, D.C. Official Code § 3-1205.22 et seq.).

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Assisted Living	

- ii. Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Individuals in Assisted Living Facilities are expected to maintain a high level of independence within and outside of the facility, with supports built into activities of daily living. Individuals who live in such independent settings have the choice of flourishing in a self-governing, semi-structured enriched environment. These facilities provide for privacy and easy access to visitors at times convenient to the individual, and provide resources and activities in the community.

Individuals are expected to remain largely autonomous and typically as expected will require assistance in the morning with bathing and dressing, and as needed in the evenings but are expected to ambulate independently or use assistive devices outside of the residential facility and within the larger community on a daily basis. Personalized care is designed to assist individuals to remain independent. Each assisted living unit offers individuals a variety of independent amenities such as apartment style living with kitchenette, bedroom, bathroom and living room whereby individuals can choose to cook their own meals and reside in an independent environment with some help, as needed.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Participant-Directed Community Support Services	
Chore Aide	
Individual Directed Goods and Services	
Respite	
Assisted Living	
Case Management	
Adult Day Health	
Environment Accessibility and Adaptation Services	
Homemaker	
Community Transition Services	
Personal Care Aide	

Facility Capacity Limit:

The size of each facility shall be governed by the Assisted Living regulations and shall not serve more than 50 participants, as designated/approved by the Licensing division.

Scope of Facility Standards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

The Assisted Living Residence Regulatory Act of 2000 does not speak specifically to ratios but states that a residence Employ staff and develop a staffing plan in accordance with the act and based upon the following criteria:

- (A) The health, mental condition, and psychosocial needs of the residents;
- (B) The fulfillment of the 24-hours-a-day scheduled and unscheduled needs of the residents;
- (C) The size and layout of the ALR;
- (D) The capabilities and training of the employees; and
- (E) Compliance with all of the minimum standards in this act; to assure the safety and proper care of residents in the Assisted Living Residence.

EXPLANATION OF HOW HEALTH AND WELFARE OF PARTICIPANTS IS ASSURED IN THE STANDARD FOR INCIDENT REPORTING

The District uses a variety of mechanisms to monitor the health and welfare of waiver participants, including a complaint database and a DLTC Monitoring Unit that serves as a point of contact for identifying complaints and incidents and initiating appropriate actions in response to such complaints and incidents. Specifically, when an incident is reported to the DLTC Monitoring Unit by a provider, beneficiary or another entity, the unit contacts the beneficiary's provider and initiates one of the following activities: refers the incident to the Adult Protective Services (APS), refers the incident to another appropriate agency or begins a corrective action immediately. The process to address the complaint begins with a combination of the following: an announced or unannounced visit to the provider agency and/or beneficiary's home or a conference call between all parties to discuss the complaint. Also, the DLTC Monitoring Unit will review clinical records, personnel files, complaint/incident binders, etc. to obtain additional, relevant information. DLTC staff will recommend that the provider, in conjunction with the beneficiary, develop or revise a plan to prevent similar incidents from occurring in the future. Also, providers must file an electronic incident report within 24 hours of incident occurrence through the District's electronic case management system, Casenet. Such reports are reviewed by the DLTC Monitoring Unit and the above-referenced actions are initiated.

With regard to critical events or incidents, there is a requirement that each EPD Waiver provider must submit through Casenet and/or via fax any unusual incident report within 24 hours. This includes falls that result in hospitalization, perceived abuse or neglect or major injury to a client. This information is placed in an unusual incidents log at DHCF that includes the specifics of the accident or unusual incident. DLTC staff contacts the provider and request specific details of the event including mitigation response/s and future adjustments to the plan of care, as warranted. DHCF staff monitors the provider and client for health and safety concerns. If the provider was at fault and made no corrective actions, the client is moved to another provider and provider may receive sanctions, including DHCF and Health Regulation Licensing Administration (HRLA) visits, no new referrals to the provider until all necessary corrective actions are taken. In the event of egregious actions, the cases are referred to the DHCF Office of Program Integrity, Medicaid Fraud and Control Unit of the Inspector General, as needed. If the incident or event is properly addressed DHCF notes in log follow-up response or follow-up during next provider visit. Data collected from the provider is also gathered on a quarterly basis, and reported on in the Continuous Quality Improvement Report, and shared with CMS in the District's EPD Waiver quarterly report.

With respect to corrective action planning (CAP), the EPD Monitoring teams goal is to ensure the provider agency is in compliance with its provided CAP. The EPD Monitoring team will make an unannounced visit to follow-up with the provider within a 60 calendar day time frame, to ensure remediation activities are concurrent with the CAP plan submitted by the provider. If the subsequent EPD Monitoring Team demonstrates the provider is not implementing its CAP according to the submitted specifications, the provider must supply another CAP within 15 calendar days and DHCF will impose sanctions. The sanctions policy is in development and ranges from the suspension of new referrals to the provider, to a letter with the intent to terminate the provider from DC Medicaid enrollment.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

(a) The District does make payments to legally responsible individuals for furnishing personal care aide, or similar services (respite, chore aide) for individuals who do not self-direct. Some family members may also receive compensation for PCA or similar services. According to the rules, a waiver recipient may choose an individual or a family member other than a spouse, or parent of a minor recipient, or other legally responsible relative to provide PCA or similar services (chore aide, respite). However, parents of adult recipients, legally responsible or otherwise, may provide PCA or similar services. All legally responsible persons or relatives must obtain the same training requirements as other personal care aides, chore aides, or respite staff.

For example, a legally responsible person or relative providing PCA services shall meet the following requirements:

1. Be at least 18 years of age.
2. Be a citizen of the US or lawfully authorized to work in the US.
3. Complete a home health aide training program which includes at least 75 hours of classroom training, with at least 16 hours devoted to supervised practical training, and pass a competency evaluation for those services which the PCA is required to perform, consistent with the requirements set forth in 42 CFR 484.36, and provide a copy of the certificate and competency evaluations.
4. Be certified in cardiopulmonary resuscitation (CPR) and obtain CPR certification annually.
5. Be able to read and write the English language at a 5th grade level and carry out instructions and directions.
6. Be able to recognize an emergency and be knowledgeable about emergency procedures.
7. Be knowledgeable about infection control procedures.
8. Be acceptable to the recipient and not be a spouse, parent of a minor recipient, or other legally responsible relative.
9. Demonstrate annually following the Centers for Disease Control guidelines that s/he is free from communicable disease, as confirmed by a chest x-ray or by an annual Purified Protein Derivative (PPD) Skin Test or documentation from a physician stating that the person is free from communicable disease.
10. Pass a criminal background check pursuant to the Health Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999, DC Law 12-238.
11. Provide documentation of acceptance or declination of the Hepatitis vaccine.
12. Be supervised by a registered nurse.

Payment may be made for the following personal care or similar services as follows: basic personal care, including bathing, grooming, assistance with toileting, or bed pan use; changing urinary drainage bags; assisting recipients with self-administered medications (aide may remind but cannot administer the medication to the recipient); reading and recording temperature, pulse, and respiration; observing and documenting the recipients status and verbally reporting to the RN or the case manager the findings immediately for emergency situations and within four hours for other situations; meal preparation in accordance with dietary guidelines and assistance with eating and feeding; tasks related to keeping the recipients living areas in a condition that promotes the recipients health, comfort, and safety; accompanying the recipient to medically-related appointments or place of employment; providing assistance at the recipients place of employment; shopping for items to promote the recipients nutritional status and other health needs; recording and reporting to the supervisory health professional and case manager any changes in the recipients physical condition, behavior, or appearance; infection control; and accompanying the recipient to approved recreational activities.

(b) A physician or Advanced Practice Nurse makes the determinations for the amount of personal care or similar services provided by a legally responsible individual in the form of a clinical and risk assessments, and an additional assessment form, which is used to assess the degree of assistance participants require. The determination of extraordinary care provided by a legally responsible individual exceeding the ordinary care that would be provided to a person without a disability of the same age is also made by a physician or an Advanced Practice Nurse.

(c) The controls employed to ensure that payments are only made for services rendered include PCA service limitations. The limitations on the amount of PCA services for which payment may be made shall not exceed sixteen (16) hours per day, up to seven (7) days per week. Additional limitations include: PCA services shall not include the requirement of a skilled licensed professional; shall not include tasks performed by chore aides; shall be available seven (7) days per week; shall be provided at place of employment, in transit, and in residence; and shall not be reimbursed if provided in a hospital, nursing facility, intermediate care facility, institution for mental disease, or assisted living facility.

When different services are rendered by two employees from the same agency, all RN visits shall be coordinated so that the supervisory in-home RN visits are in accordance with waiver standards and supervisory RN visits are made by the same supervising RN at the same time.

Similarly, when a legally responsible individuals or family member provides other similar services (i.e., respite, chore aide, or homemaker services), they must obtain the same provider qualification/training as specified in the requisite Provider Qualification sections under Appendix C.

Self-directed

Agency-operated

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

The State will allow payments to be made to relatives/legal guardians under special circumstances.

The following applies to adult day health, EAA, and Assisted Living waiver services: The District enrolls provider entities and not professionals directly. DHCF does not prohibit payment to waiver participants' relatives/legal guardians who are hired by the entities and does not prohibit a relative/legal guardian's own provider entity from being enrolled as a Medicaid provider. Medicaid payments are made to the enrolled provider entity.

The case manager, through the person-centered planning process, assists the individual and responsible party to plan the services that reflect the individual's personal preferences, choices and safeguards their health and welfare. Additionally, case managers ensure that the individual is receiving services in accordance with the person-centered plan throughout the Waiver year and especially during the face-to-face monthly monitoring visits. It is often times during these visits, along with the quarterly PCP reviews, that the case managers can determine whether services are or are not provided in the best interest of the person. If a case manager suspects that services are not provided in the "best interests" of the beneficiary, they can report the finding to DHCF's LTCA for review and guidance by DHCF's Office of the General Counsel. Case managers are also required to report instance of abuse or neglect to Adult Protective Services. Additionally, the LTCA's oversight and monitoring unit randomly reviews cases where the legal guardian provides services to ensure that services are being provided in accordance with the PCP. Case Managers plan services through the person-centered planning process and the person-centered plan (PCP) identifies goals and related services. The PCP is reviewed by DHCF or its designee for issuing the prior-authorization for the services. Case managers conduct monthly visit to ensure that services are furnished and addressing the person's needs. If service deficiencies are noted, case managers identify and resolve them. If service change is needed, PCP is amended to reflect the changes. Additionally, DHCF's oversight and monitoring Division reviews randomly selected cases on a quarterly basis to ensure that services were rendered in accordance with the ISP and in the best interest of the individual. Discovery/remediation is generated for deficiencies identified and followed upon until issue resolution. The cases that are suspected of fraud are referred to DHCF's Program Integrity Division for further review and audit.

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The following processes are used to assure that all willing and qualified providers have the opportunity to enroll as Waiver providers. All qualified Waiver providers are accepted as providers of care. All criteria for Waiver providers are printed and available to any and all interested providers. This information is available online at www.dc-medicaid.com, as well as with the DHCF Division of Public and Private Provider Services.

The provider enrollment process is open to all willing and qualified providers. Each provider has the opportunity to enroll if they meet the approved qualified criteria (State/local and Federal criteria, e.g. District licensure requirements and requisite Code of Federal regulations for the provision of services) for provision of services for the EPD Waiver.

Providers have ready access to information regarding requirements and procedures to qualify for enrollment online at www.DC-Medicaid.com. This site maintains all appropriate EPD Waiver provider information concerning enrollment and also provides LTCA contact information.

The Readiness Process is initiated by the prospective provider submitting a letter of interest to the EPD Waiver Branch at expressing an interest in becoming an EPD Waiver provider. Prospective providers are expected to forward the letter to the following address: LTCAprovider@dc.gov. The letter of interest must include the following:

- Name of the agency with proof of current incorporation in the District of Columbia;
- Contact person with a postal mailing address, business email address and telephone number;
- Brief description of the type of services they would like to provide; and a
- Brief statement of the agency's readiness to provide the service(s) for which approval is requested. The statement must provide evidence of knowledge and understanding of the relationship between State Plan and Waiver service as related to the service provision(s) for which the applicant is seeking approval.

Within seven (7) business days of the receipt of a letter of interest from a prospective provider, LTCA will respond to the prospective provider via email and provide an overview of the readiness process including a contact person for technical assistance, a checklist of required information, and information on attending a mandatory prospective provider information session.

The prospective provider is required to attend an information session coordinated by LTCA. The information session will include an overview of the Department of Health Care Finance's mission statement and commitment to federal assurances and performance goals related to the administration and operations of a Home and Community-Based Waiver Service Program. The prospective provider should arrange for availability of key individuals involved with the program/service under review to attend this session. An application for enrollment as an EPD waiver provider must be submitted within sixty (60) business days from the date of attendance at the prospective provider information session.

DHCF anticipates processing applications for participating in the Home and Community Based Medicaid Waiver Services Program within thirty (30) business days of receipt of a complete application packet (Medicaid Application/Agreement and Program Policies and Procedures).

The application should include but not limited to the following: A description of ownership and a list of major owners, a list of Board members and their affiliations, a roster of key personnel, their qualifications and a copy of their positions descriptions, copies of licenses and certifications for all staff providing medical services, the address of all sites at which services will be provided to Medicaid participant, copy of the most recent audited financial statement of the organization, a completed copy of the basic organizational documents of the provider, a detailed organizational chart including all current employees, current articles of the incorporation, copy of the by-laws or similar documents regulating conduct of the provider's internal affairs, copy of the business license, a copy of Joint Commission certification and the submission of any other documentation deemed necessary by DHCF for the Medicaid provider enrollment process; additional requirements are Quality Improvement Plan, admission process, Code of Conduct, policies and procedures, and agency complaint process.

Incomplete applications submitted to DHCF will be returned within fifteen (15) days of receipt; applicants have ten (10) business days to provide DHCF with all requested information/documentation. If the information/documentation is not provided to DHCF within ten (10) business days, the application is then returned to the prospective provider, who is welcome to reapply at any time in the future.

Provider applications are submitted to the Fiscal Intermediary, who in turn scans the application and submits the document to the Division of Public and Private Provider Services.

Provider Services reviews the application in accordance with Federal and District screening requirements. Requirements include verification of the submission of the disclosure of ownership form, NPI/Taxonomy Code, liability insurance, surety bond (applicable to those providers rendering PCA services), and checking the Federal exclusion databases.

The application is then sent to the DHCF Division of Long Term Care (DLTC) for review.

The application review will include several components depending on the type of service and the number of services being requested. However, minimally the EPD Waiver Branch will review the following:

- Organizational Policies and Procedures Review
- Financial/Business Plan Review
- Health Care Coordination Plan
- Service and Support Planning

Each component must be satisfied before the prospective provider can be considered qualified. If the applicant fails to successfully satisfy any of the components, the application will be returned and the applicant may reapply following attendance of another Prospective Provider Information Session which will be held quarterly. Each resubmission requires attendance at a Prospective Provider Information Session no more than sixty (60) days prior to the application (re)submission date.

When the EPD Waiver Branch receives the Medicaid Waiver application and the required supplemental materials, the documentation is reviewed by provider readiness review committee (PRC). The Provider Review Committee is a committee composed of representatives from Long Term Care Administration (LTCA) Staff. LTCA staff may include or consult with the Division of Quality & Health Outcomes, the Division of Public and Private Provider Services and the Healthcare Policy & Research Administration when needed. The Provider Review Committee is charged with the responsibility to review each “new” application and actively participate in the screening and selection or denial process. Within seven (7) days of receipt of a complete application, LTCA forwards all financial components to the Office of Rates, Reimbursement and Financial Analysis (ORRFA) for review.

An assigned Committee chair is responsible for coordinating and scheduling all activities related to reviewing, discussing, meeting and reporting final determinations from the committee. The LTCA staff complete the EPD Provider Qualification Checklist to begin the review. The assigned LTCA staff persons will review reports, if applicable, from other District, federal and or state agencies and evaluate results/outcomes.

Each committee member is expected to read and evaluate each application prior to the meeting. Specifically, each committee member will:

- Review each provider application and supplemental material in its entirety;
- Complete the review and tasks in accordance with the established deadlines;
- Submit comments on the application at least five business days before the scheduled meeting; and
- Attend the entire duration of the committee meeting.

During review meetings, each team member will ask questions to validate that the prospective provider satisfies the requirements described in the established criteria. Additionally, at the completion of the Readiness review, the review team will list strengths, weaknesses and actionable items for staff assigned if further review is needed. The provider readiness review includes an on-site visit, which should be coordinated with staff from Division of Public and Private Provider services. The team will complete a readiness review that may include a face-to-face interview/meeting with key prospective provider personnel.

The results of the Provider Review Committee are documented in a report prepared by the chair. The final report with comments and recommendations are sent to the EPD Project Manager. The recommendations to approve or to deny an application are routed for agency review and approval process from LTCA Director through Operations Director to the Medicaid Director, who in turn consults with the Office of General Counsel.

If the application is rejected because of insufficient information the provider is given thirty days to submit the appropriate information. When requested information is not submitted to DHCF within the specified time frame, the application is returned to the provider as it is assumed he/she is no longer interested in providing services for the District of Columbia. He/she however, is given the opportunity to submit another application at their leisure.

If the application is approved, LTCA will send it over to Division of Public and Private Services. Provider must respond to a request for criminal background checks/fingerprints for all of the names listed on the disclosure of ownership form. They have 30 days from the date of the letter to respond. If no response is provided, the application is denied. If they respond timely and there are no deficiencies, then they will be notified of a request to attend the Mandatory Provider orientation conducted by the fiscal agent for programmatic and billing services.

The orientations consist of all policies and procedures of the EPD waiver program, review of requisite rules, program integrity overview, and billing. Once the provider attends the provider orientation, then DHCF will sign the provider agreement and the fiscal agent will assign a DC Medicaid provider number and issue a Welcome Letter to the provider.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. *Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percent of providers by type who continue to meet EPD Waiver Qualifications.

Number of existing providers by type who continue to meet EPD Waiver Qualifications (numerator). Number of existing providers (denominator).

Data Source (Select one):

Other

If 'Other' is selected, specify:

Health and Regulation and Licensing Administration (HRLA) Spreadsheet

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="HRLA"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percent of providers enrolled who meet provider readiness. Number of new providers who meet provider readiness (numerator). Number of providers enrolled (denominator).

Data Source (Select one):

Other

If 'Other' is selected, specify:

Program Operations Spreadsheet

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percent of providers that train staff according to DHCF EPD policies and procedures. Number of providers that meet all training indicators on the Provider annual monitoring audit (numerator). Number of providers reviewed (denominator).

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

DHCF has in place several mechanisms to monitor and analyze EPD waiver performance. The LTCA Oversight and Monitoring Division conducts compliance reviews on performance measures of all waiver assurances. The LTCA Oversight and Monitoring Division is responsible for the discovery and remediation process of individual and systemic issues.

On a monthly basis the Division of Quality and Health Outcomes (DQHO) in concert with the LTCA Oversight and Monitoring Division convenes a Quality Management Committee (QMC). The purpose of QMC is to provide oversight of the EPD program to evaluate the performance and implement quality improvement strategies for continuous quality improvement.

Performance measures are derived from the actual EPD waiver measures approved by CMS or other measures that the program feels are important to monitor. A report card of measures is maintained in the DQHO. The EPD staff submits performance rates to DQHO for tracking and trending. Once performance measure rates are submitted to the DQHO, an analysis is completed on individual performance measures and overall program performance.

The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF.

Additionally, DHCF utilizes a work plan that tracks performance and prioritizes improvement efforts and implementation of the Plan-Do-Check-Act quality improvement process. The work plan will be utilized to formally develop the written quality strategy. This strategy will be in compliance with CMS's national initiatives for home and community based settings. This strategy will be aligned with the National Quality Strategy of better care, healthy people, healthy communities, and affordable care. This program will fit within the Agency's strategic mission and strategic goals.

Task 1. The DQHO partners with the LTCA Monitoring and Oversight Division to conduct a comprehensive program evaluation of the previous EPD waiver program. This evaluation will include an analysis of all components of the EPD waiver. It shall include an iterative process for assessing quality performance, identify opportunities for improvement, and outline recommendations for targeted quality improvement processes and measuring and monitoring of the program's overall effectiveness. This evaluation will be completed by April 2017.

Task 2. The program analysis in addition to the work plan will be used to develop a comprehensive five year quality strategy. The quality strategy will include a process for assessing and revising performance measures at least annually.

Task 3. Provisions will be included to ensure that all applicable providers delivering services to waiver participants shall be subject to quality standards, including but not limited to, guidance issued by the Centers for Medicare and Medicaid Services (CMS) and rules issued by DHCF related to quality improvement activities. All applicable service providers shall be subject to quality standards that adhere to CMS and DHCF guidance related to DHCF's EPD quality strategy, and provide for a continuous Quality Assessment and Performance Improvement (QAPI) program consistent with these requirements.

The quality strategy will be completed and implemented by December 2017.

There are two different types of reviews. One review (used for this performance measure) is the program monitoring audit which is an annual review and includes 100% of the providers. The audits performed for the performance measures in Appendix I-1 are program integrity audits and are conducted quarterly on a sample of claims.

There is 100% review of all providers and each provider is required to do 100% training of all employees. In DHCF's review we select a random sample of the employee records to review to ensure compliance. Consumer Direct, our vendor for PDS, does 100% review for participant directed workers and DHCF does a sample as stated above. This is part of the annual monitoring referenced in Appendix D-2-a.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

In order to qualify for Medicaid reimbursement, EPD Waiver Providers shall comply with programmatic requirements as part of its Provider Readiness Review and enrollment. The programmatic requirements include adherence to acceptable standards in the following areas:

- (1) Service Delivery as governed by the provider requirements and duties established under Appendix C's- Service Description Section;
- (2) Program administration as governed under mandated policies and procedures;
- (3) EPD Waiver-related Performance Measures;
- (4) Staffing and training; and
- (5) Home and Community Based Services (HCBS) setting requirements.

DHCF may impose alternative sanctions against an EPD Waiver provider:

- (1) In response to a complaint;
- (2) In response to an incident report;
- (3) Upon recommendation by DHCF's Division of Program Integrity; or
- (4) Upon recommendation by DHCF's LTCA EPD Waiver Monitoring Unit.

DHCF shall determine the appropriateness of alternative sanctions based on the following factors:

- (1) Seriousness of the violation (s);
- (2) Number and nature of the violations(s);
- (3) History of prior violations(s);
- (4) Potential for serious harm to beneficiaries;
- (5) Recommendation(s) by DHCF's Division of Program Integrity or LTCA EPD Waiver Monitoring Unit; or
- (6) Other relevant factors.

DHCF may impose one or more of the following alternative sanctions if the violation does not place the beneficiary's health or safety in immediate jeopardy:

- (1) Imposition of a correction action plan;
- (2) Imposition of a cap on enrollment;
- (3) Denial of new admissions;
- (4) Imposition of an enhanced monitoring plan;
- (5) Withholding of provider reimbursements; or
- (6) Temporary suspension of the provider from participation in the EPD Waiver program.

DHCF shall publish rules which set forth the process and procedures governing the imposition of alternative sanctions.

DHCF reserves the right to terminate the provider agreement in accordance with the requirements set forth in Chapter 13 of Title 29 DCMR if the agency determines that alternative sanctions are inappropriate.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Specify: <div data-bbox="863 282 1339 360" style="border: 1px solid black; height: 35px; margin-top: 10px;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

As mentioned in question ii (Methods for Discovery), DHCF has in place several mechanisms to monitor and analyze EPD waiver performance. The LTCA Oversight and Monitoring Division conducts compliance reviews on performance measures of all waiver assurances. The LTCA Oversight and Monitoring Division is responsible for the discovery and remediation process of individual and systemic issues.

On a monthly basis the Division of Quality and Health Outcomes (DQHO) in concert with the LTCA Oversight and Monitoring Division convenes a Quality Management Committee (QMC). The purpose of QMC is to provide oversight of the EPD program to evaluate the performance and implement quality improvement strategies for continuous quality improvement.

Performance measures are derived from the actual EPD waiver measures approved by CMS or other measures that the program feels are important to monitor. A report card of measures is maintained in the DQHO. The EPD staff submits performance rates to DQHO for tracking and trending. Once performance measure rates are submitted to the DQHO, an analysis is completed on individual performance measures and overall program performance.

The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF.

Additionally, DHCF utilizes a work plan that tracks performance and prioritizes improvement efforts and implementation of the Plan-Do-Check-Act quality improvement process. The work plan will be utilized to formally develop the written quality strategy. This strategy will be in compliance with CMS's national initiatives for home and community based settings. This strategy will be aligned with the National Quality Strategy of better care, healthy people, healthy communities, and affordable care. This program will fit within the Agency's strategic mission and strategic goals.

Task 1. The DQHO partners with the LTCA Monitoring and Oversight Division to conduct a comprehensive program evaluation of the previous EPD waiver program. This evaluation will include an analysis of all components of the EPD waiver. It shall include an iterative process for assessing quality performance, identify opportunities for improvement, and outline recommendations for targeted quality improvement processes and measuring and monitoring of the program's overall effectiveness. This evaluation will be completed by April 2017.

Task 2. The program analysis in addition to the work plan will be used to develop a comprehensive five year quality strategy. The quality strategy will include a process for assessing and revising performance measures at least annually.

Task 3. Provisions will be included to ensure that all applicable providers delivering services to waiver participants shall be subject to quality standards, including but not limited to, guidance issued by the Centers for Medicare and Medicaid Services (CMS) and rules issued by DHCF related to quality improvement activities. All applicable service providers shall be subject to quality standards that adhere to CMS and DHCF guidance related to DHCF's EPD quality strategy, and provide for a continuous Quality Assessment and Performance Improvement (QAPI) program consistent with these requirements.

The quality strategy will be completed and implemented by December 2017.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The Statewide Transition Plan is under review by CMS

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Elderly and Physical Disabilities Waiver

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

- b. Service Plan Development Safeguards.** *Select one:*

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The State will ensure that consumers (and/or family or legal representative, as appropriate) are supported to direct and actively engage in the development of their service plan. First, the District's Aging and Disability Resource Center (ADRC) works with consumers to select and rank three preferred case management agencies (CMA). During this initial interaction with the consumer, the ADRC shares a list of CMAs so that the consumer is able to select and rank available CMA agencies. The ADRC reaches out to each CMA selected by the consumer, and works to ensure that the consumer is matched with his/her preferred CMA. If a CMA is unable to accept the consumer, the ADRC will connect with the consumer's next preferred CMA. Once the consumer is determined eligible for the EPD waiver program, the ADRC conducts a 'warm' hand-off of the consumer to the CMA, which includes developing notice/summary of all ADRC work with consumer, services being received, etc. The selected CMA must contact the consumer within 24 hours and use a person-centered approach to developing the consumer's service plan.

During the development of the consumer's service plan, the case manager shall commit to making services fit individuals, rather than making individuals fit services, and enable a person-centered planning process, directed by the individual with long-term services and support needs (or a representative they choose), that meets the following requirements:

1. Occurs at a time and location that is convenient for the person and any other individuals that person wants included in the planning;
2. Includes face-to-face discussions with the person whose plan is being developed, other contributors chosen and invited by the person, and representatives of the person's interdisciplinary team, if possible;
3. Ensures that information shared with the person is aligned to his or her acknowledged cultural preferences and communicated with in a manner that ensures the person and/or his or her representative understands the information; and
4. Embraces the personal preferences of the individual to develop goals and to meet the person's needs.

The case manager ensures that during the assessment process he/she informs the consumer and/or family or legal representative about his/her authority to include all individuals of his/her choice to participate in the service planning and development process. The case manager must also ensure that the Individual Service Plan (ISP) process is thoroughly explained and describes all support services available through the EPD Waiver program that could assist the participant, as appropriate, to successfully and safely live in the community. Furthermore, the case manager explains the role of the service provider agency to the participant in addition to providing him/her with the list of provider agencies that the participant can select from. The case manager and the consumer discuss the appropriate service needs and frequency with which each service will be provided. The discussion also entails the selection of the provider agency to provide each service. Finally, the case manager must inform the participant of his/her freedom of choice of providers during this initial meeting and at all subsequent meetings to include quarterly, mid-year and annual assessment and planning meetings, should a situation arise at any point which requires consideration of a provider change. The case manager also has the responsibility of ensuring that the freedom of choice of service and provider drives the planning process.

A standardized person-centered planning format is used throughout the planning development process. The service plan is developed by case manager and the consumer and/or family or legal representative, along with a multidisciplinary team of individuals involved in the consumer's care. These team members know and work with the consumer and their active involvement is necessary to achieve the outcomes desired.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

WHO DEVELOPS THE PLAN, WHO PARTICIPATES IN THE PROCESS, AND THE TIMING OF THE PLAN

The service planning process assures that persons have access to quality services and supports that promote independence; learning; growth; choices in everyday life; meaningful relationships with family, friends and neighbors; presence and participation in the fabric of community life; dignity and respect; positive approaches aimed at skill development; and health and safety. The planning process is driven by the person's vision, goals, and needs with overall management and facilitation provided by the Case Manager.

The Case Manager is responsible for developing the person's service plan using a person-centered approach. Using this approach, the Case Manager ensures that the resulting person-centered service plan highlights the person's strengths and that it aligns with the person's articulated quality of life goals, service and support needs, and preferences. The person, as well as others that he/she chooses, are engaged in the development of the service plan. Within ten (10) days of a Case Manager's initial contact with the person, the Case Manager must develop the service plan. During this time period, the Case Manager meets with the person at a time and location that is convenient for the person, and any other individuals the person wants to include in the planning. Additionally, the Case Manager must ensure that the process used to develop the person's person-centered service plan meets the following requirements:

1. Includes face-to-face discussions with the person whose plan is being developed, other contributors chosen and invited by the person, and representatives of the person's interdisciplinary team, if possible;
2. Incorporates feedback of members of the person's interdisciplinary team and other key people chosen and invited by the person;
3. Ensures that information shared with the person is aligned to his or her acknowledged cultural preferences and communicated in a manner that ensures the person and/or his or her representative understands the information.

Communication must be consistent with the policies/practices of the US Health and Human Services Office on Minority Health Standards National Standards on Culturally and Linguistically Appropriate Services (CLAS)

<http://www.minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>. If needed, auxiliary aids and services should be provided;

4. Provides meaningful access to persons and/or their representatives with limited English proficiency (LEP), including low literacy materials and interpreters;
5. Uses a strengths-based approach to identifying the positive attributes of the person, including an assessment of the person's strengths, preferences, and needs;
6. Embraces the personal preferences of the person to develop goals and to meet the person's needs;
7. Explores employment and housing in integrated settings, where planning is consistent with the person's goals and preferences, including where the person resides and who they live with; and
8. Ensures that persons under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, have the opportunity to address any concerns related to the person-centered Individual Service Planning process.

TYPES OF ASSESSMENTS THAT ARE CONDUCTED TO SUPPORT THE SERVICE PLAN DEVELOPMENT PROCESS

Multiple assessments of the person occur before the Case Manager develops the person's service plan. The assessments that occur prior the service plan development, and the order in which they occur, are below.

1. The District of Columbia's Office on Aging's, Aging Disability and Resource Center is the first point of contact in the pathway for a DC resident to request long term care services and supports. The ADRC collects general information and demographics and counsels the Applicant on available services. If a person requests long-term care services, an Enrollment Specialist (ES) will be assigned to assist the person with the application process for the EPD Waiver Program.
2. The ES will assist the applicant with obtaining and completing the required paperwork. These include, but are not limited to, the following documents:
 - a) Clinician authorization;
 - b) Rights and Responsibilities;
 - c) Freedom of Choice form;
 - d) Proof of Residency;
 - e) Proof of Income and other supporting financial documentation;
 - f) Medicaid Application (if currently not a Medicaid beneficiary; and
 - g) LTC Application and Attestation/Case Management Agency (CMA) Selection

3. The ES also assists the applicant in requesting a level of care assessment, to be conducted by the Long-Term Care Services and Supports Contractor (LTCSS Contractor).
4. DHCF's LTCSS Contractor conducts a face-to-face assessment of the person's functional, behavioral, and skilled care needs to determine level of care and determine need for EPD waiver services.
5. When the LOC is approved via the assessment tool, the ES is responsible for ensuring that the information is transmitted to ESA, and ESA is responsible for determining financial eligibility.
6. ESA receives the EPD Waiver Certification report/spreadsheet and performs the financial assessment and makes the determination of financial eligibility.
7. The disposition of financial assessment is sent to DHCF and ADRC via a Report, and eligibility notices are sent to the applicant and his/her Healthcare Power of Attorney (POA), if applicable.
8. The ES contacts the selected CMA on behalf of the applicant to secure acceptance. If the applicant's first choice of provider is not accepting new clients, the ES will contact the applicant's subsequent choices of CMAs until the applicant is accepted by a CMA.
9. DHCF issues a prior authorization to enable the CMA to begin billing.
10. The ADRC, DHCF, and CMA hold a meeting to transfer the case to the Case Manager.

HOW THE PERSON IS INFORMED OF SERVICES AVAILABLE UNDER THE WAIVER

During a Case Manager's initial contact with the person, and others that the person chooses to engage in the planning, the Case Manager provides information on services and supports available through Medicaid and non-Medicaid services, including supports from the person's family, friends, faith-based entities, recreation centers, or other available community resources. Persons are again informed about each of these services during subsequent (reevaluation and interim changes) service planning development processes and as often as needed should any circumstance arise that may warrant an interest in needing new services and/or changing providers. Also during the initial contact and at least annually, Case Managers inform the person that they can select any service provider they want including selecting a different provider for each service (if they choose to) without jeopardizing participation in the waiver. Furthermore, the Case Manager communicates with the person that he/she can request a change in services and/or provider at any time. Case Managers ensure that persons and/or their legal representatives understand their ability to select their services and providers so that the person is able to complete the Freedom of Choice form related to a person's choice between waiver services and institutional care, and choice between/among waiver services and providers.

In addition, the Case Manager also provides the person, and others chosen by the person, and their representatives with the web address for the Department of Health Care Finance (DHCF) website at: <http://dhcf.dc.gov> and the District of Columbia Office on Aging (DCOA) website at <http://www.dcoa.dc.gov>, where all of the waiver services are listed.

HOW THE PLAN DEVELOPMENT PROCESS ENSURES THAT THE SERVICE PLAN ADDRESSES THE PERSON'S GOALS, NEEDS AND PREFERENCES

The person's service plan must incorporate the following required components:

1. The person's prioritized personal outcomes and specific strategies to achieve or maintain his/her desired personal outcomes, focusing first on informal and community supports and, if needed, paid formal services;
2. An action plan which will lead to the implementation of strategies to achieve the person's identified desired personal outcomes, including action steps, review dates and timelines and the responsible individual for each identified action, ensuring that the steps which are incorporated empower and enable the person to develop independence, growth, and self-management;
3. Target dates for the achievement/maintenance of the person's personal outcomes;
4. Identify the person's preferred formal and informal service providers and specification of the service arrangements; and
5. Ensures the person and individuals selected by the person sign the service plan attesting to their agreement to participate in the implementation of the person's plan and that the person's goals, needs, including health care and preferences are addressed.

HOW THE PLAN DEVELOPMENT PROCESS PROVIDES FOR THE ASSIGNMENT OF RESPONSIBILITIES TO IMPLEMENT AND MONITOR THE PLAN

The development of the person's plan ensures that individuals selected by the person to help create, and participate in the implementation and monitoring of the person's ISP are identified, and that the roles and assigned responsibilities of these selected individuals are clear and understood. To confirm that those that have agreed to contribute to the person's plan understand their assigned responsibilities, the Case Manager shall ask that each individual sign the PCP.

The Case Manager monitors the activities and performance of those included in the person's interdisciplinary team, including, but not limited to:

- RN: at set intervals and/or upon request of the person, the Case Manager confirms that services requiring RN intervention (such as PCA services) are occurring and that their services are documented in clinical notes; and;
- Physician (or RN): who is employed by the PCA Provider shall review the beneficiary's plan of care under which PCA services are delivered at least once every sixty (60) days, and shall update or modify the said plan of care as needed.

Furthermore, the Case Manager will assist with the coordination of all services including waiver and non-waiver services identified as a need to ensure that the assigned responsibilities facilitate the person remaining in the community setting safely. The Case Manager will contact the selected direct care providers and discuss the number of hours the person is assessed to need, as well as non-waiver service providers/ resources to assess any changes in available support. The Case Manager will contact the person, as well as others chosen by the person, to evaluate the person's satisfaction with the services received.

HOW AND WHEN THE PLAN IS UPDATED

The Case Manager shall work with the person to implement the person-centered PCP, and ensure that the PCP is updated at set time intervals, or more frequently if needed and/or requested by the person.

Specifically, the Case Manager shall:

1. Assist with initiating services and accessing community supports;
2. Coordinate care across the various and multiple services and /or providers connected to the person's service plan, regardless of source of payment;
3. Monitor the person to ensure that needs and preferences are being met and that the person receives services described in the person's ISP in type, scope, duration, and frequency. If results of routine monitoring activities necessitate updates to the ISP, this should be done within seven (7) days of said monitoring activity, with mandatory signatures of the person and the Care Manager.
4. Review and update the ISP at least every twelve (12) months or when the person's functional needs change, circumstances change, quality of life goals change, or at the person's request.
 - a. The Case Manager must respond to the person's requests for updates within forty-eight (48) hours, with completion of the update within seven (7) days.
 - b. The updated ISP must be done via face-to-face discussions with the person whose plan is being developed, other contributors chosen and invited by the person, and representatives of the person's interdisciplinary team, as possible.
 - c. The updated ISP must incorporate feedback of members of the person's interdisciplinary team and other key individuals if and when they are unable to participate in face-to-face discussions inclusive of the person.
 - d. The updated ISP must include approval signatures the person and the Case Manager.
5. Assist in obtaining required documents for the initiation of and on-going maintenance of services (e.g., securing physician orders, etc.), particularly at the time of required renewals and recertification;
6. Ensure quality of care and service provision, including identification and resolution of problems with providers and services identified in the ISP;
7. Provide supportive counseling to the person and family, as appropriate.
8. Maintain records to provide supportive documentation of all conflict-free care management services provided. All records must be maintained in a manner consistent with District of Columbia privacy and confidentiality rules.
9. Ensure that Medicaid renewals and any required re-certifications are complete before the end of a person's renewal or certification period, including ensuring the person obtains annual level of care redetermination.
10. Monitors implementation of ISP via monthly (at minimum) check-ins that are documented in DC's electronic care management system to ensure that persons are receiving services per their plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Health Risk Assessment and Mitigation Plan efforts are conducted on admission (the initial visit) to identify, analyze and prioritize risks associated with the beneficiary's conditions which will impact the provision of EPD Waiver Services. The application of this Risk Assessment is incorporated in the clinical health assessment. A Risk Management Plan and a corresponding proposed action (mitigation) plan will be developed and implemented for identified risks. The ISP will address any and all of the identified risks resulting from the comprehensive health clinical health assessment. Described in the ISP will be what each service provider will do to try and avoid any negative outcomes from the identified risk factors.

Purpose: The purpose of the risk assessment is to react to events that could occur and may impact upon the scope and delivery of services. Risks are measured in terms of their likelihood of occurrence and their impact of the beneficiary as well as the Waiver services.

Objective: To ensure that the perceived risk and scope are proactively identified, communicated and mitigated in a timely manner.

Each provider agency CM should ensure there are contingency plans (back-up plans) in case of emergency situations. There shall be a designated person to contact in case of emergency. All staff that provides direct care shall be well versed (current in certification as applicable) in emergency techniques such as CPR and the individualized contingency/back-up plans. All contingency plans shall be documented in the ISP and a copy of the plan should be in the beneficiary's home where it is readily accessible.

The contingency/back-up plans will be developed with the case manager, beneficiary, and any person that the beneficiary identifies need to have input in the decision making of the plan. Some types of contingency/back-up plans are: a designated person to be responsible for the care of the beneficiary in case there is no PCA available to provide care for a specified shift in case of a call-in; a designated person to be responsible for the care of the beneficiary every day when the PCA leaves if the beneficiary receives 16 hours per day of care by a PCA; in case there is a massive snow storm and no PCA can get to the beneficiary's home to assist the beneficiary; and the case management ensuring and assisting with placing the beneficiary's name on the list that the fire department uses to know which individuals will need assistance evacuating in case of a fire (the list is called the CAD List which stands for Computerize Aided Dispatch).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Case managers will inform and remind consumers of the freedom of choice in the selection of all providers at all meetings/visits/telephone calls as needed.

Potential consumers are made aware of the EPD Waiver providers and services through DHCF brochures, DC Office on Aging, the provider listing, the Aging and Disabilities Resource Center (ADRC), DHCF website (<http://dhcf.dc.gov>), Ombudsman Office, during each visit from the RN/CM/PCA, as well as word of mouth. The case manager informs applicants and beneficiaries about all services at initial and subsequent meetings.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The process for the approval of the ISP is:

1. The CM submits the completed documentation in Casenet, the electronic record system, for determination of a nursing facility level of care (LOC) by the QIO.
 2. If the QIO has questions or needs additional information the QIO will request the information by way of a task to the CM.
 3. If no additional information is needed or when all information is received then the QIO will provide approval of a LOC for one (1) year.
 4. The QIO task DHCF the approval of the LOC
 5. The DHCF forwards the information to IMA for financial eligibility determination.
 6. ESA reviews the documentation and approves the applicant for one year for the EPD waiver program or disapproves the applicant for the EPD waiver program.
 7. The documentation of the program is then forwarded to DHCF if approved for the EPD waiver program through ESA electronic system to DHCF electronic system. If the documentation is not approved for the EPD waiver it is documented in ESA electronic system and ESA notifies the applicant about the determination of which if any programs the applicant qualifies for.
 8. DHCF forwards the information to the QIO for approval.
 9. Once all information is received and the QIO review of the documentation yields positive results (no additional information needed) the QIO approves the documentation and provides an authorization number.
- The DHCF reviews annually a percentage of all EPD Waiver provider agencies records.
1. The DHCF reviewed 10% of each agencies current EPD Waiver census clinical records.
 2. The DHCF reviewed for compliance with the EPD Waiver regulations, district and federal regulations and the provider agency policies and procedures,
 3. Deficiency statements are written with a request for a plan of correction,
 4. The plan of correction is reviewed and accepted as appropriate.
- The DHCF will utilize a different methodology for selection of record review to be effective prior to the end of the calendar year 2011 to ensure the sample size is statistically valid.

Documentation reviewed by DHCF staff:

Individual Service Plan
 Client Health history (the risk assessment is incorporated in this form)
 Waiver Service Cost Sheet
 Signed Beneficiary Freedom of Choice
 Bill of Rights
 Environmental Assessment
 Individual Service Plan Agreement
 2010-1
 LOC
 30AW Form

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

The ISP is reviewed initially, quarterly, annually and revised as necessary.

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

Medicaid agency

Operating agency

Case manager

Other

Specify:

Service plans are kept by the case management agencies and DHCF maintains copies of the service plans in the Medicaid EPD electronic management system.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

All providers should inform and remind the beneficiary of the freedom of choice in the selection of all providers at all meetings/visits/telephone calls as needed.

DHCF is responsible for monitoring the implementation of the PCP. The monitoring is completed at a minimum of annually. A review of the documentation in the electronic record, complaint/incident binders and interviews is the method used by DHCF to determine whether services are furnished in accordance with the service plans; beneficiaries have access to waiver services identified in the PCP; services meet the needs of the beneficiaries; back-up plans are effective; beneficiary health and welfare is assured; beneficiaries exercise freedom of choice of providers; and beneficiaries have access to non-waiver services if identified in the ISP. Review of documentation and submission of requested reports is the method used to ensure follow-up to identified problems. DHCF keeps documentation of all deficiency reports annually electronically.

Case Management Agencies (CMA) are responsible to ensure that EPD Waiver Beneficiaries have access to services and supports needed to live in the most integrated setting including EPD Waiver, non-waiver and other health care services. CMAs are responsible to ensure that case managers conduct monthly monitoring to ensure that the timely determination of level of care, PCP development, services are delivered in the type/frequency as described in PCP as indicated in the PCP and to ensure the beneficiary's health. Additionally, CMAs are responsible to ensure that the PCP is reviewed at least quarterly to review and update risk factors, goals, outcomes, services, review service utilization and to resolve issues.

The case management agency is responsible for monitoring the staff and contractors to ensure the implementation of the PCP and the health and welfare of the beneficiary. DHCF is responsible for monitoring the case management agency to ensure the PCP was implemented and the health and welfare of the beneficiary.

DHCF monitors the case management provider agency at a minimum annually.

The monitoring and follow-up methods that are used by DHCF are as follows. The DHCF makes unannounced visits to the provider agency. DHCF conducts an entrance conference to explain the purpose of the visit and inform the provider agency of the documentation that will be needed to complete the annual monitoring visit. The DHCF request a copy of all current EPD waiver beneficiaries (i.e.: census) to randomly select a percentage of the beneficiaries clinical records to review. DHCF will also request to review records of beneficiaries that had voiced complaints about the provider agencies as appropriate. DHCF also conducts interviews of the staff as appropriate. DHCF reviews personnel files, complaint/incident binders and policies/procedure manuals. After review of the clinical records is completed DHCF selects a sample of the records reviewed to visit the beneficiaries homes. DHCF request that the provider agency staff calls the beneficiaries and arrange for the DHCF to make a home visit. DHCF meets with the provider agency and conducts a verbal exit conference. The purpose of the visit is to determine the provider agency's compliance with the EPD waiver regulations, district and federal regulations and the agency's policies and procedures. Also the visits to the beneficiaries homes will allow the DHCF to assess the beneficiaries satisfaction with the services received from the provider agencies.

After completion of the on-site visit the DHCF will return to the office and complete a statement of deficiencies (SOC) as appropriate. The SOC will be forward to the provider agency by mail, e-mail or pick-up by the agency. The agency will have fifteen (15) days to return a plan of correction.

DHCF will provide the agency with an acceptance letter of approval of the POC. If the POC is not acceptable (i.e.: lack of documentation describing how the deficiency will be corrected and plans to alleviate recurrence of the identified deficient area) the DHCF will notified the agency and request a revised POC.

b. Monitoring Safeguards. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. *Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and Percent of waiver participants who have service plans that address their personal goals
N: # of participants who have service plans that address their personal goals
D: # of participants reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		90% ERROR RATE 15
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Percent of waiver participants who have service plans that address their health and safety risks. Numerator = Number of ISPs that had revision related to changing needs. Denominator = Number of ISPs that needed revision related to changing

needs.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;">90% ERROR RATE 15</div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

**Percentage of individuals whose ISP was revised as needed to address changing needs. Number of ISPs that needed revision related to changing needs (denominator).
Number of ISPs that had revision related to changing needs (numerator).**

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">90% ERROR RATE 15</div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:**Percentage of ISPs updated at least annually. Number ISPs reviewed (denominator).****Number of ISPs updated at least annually (numerator)****Data Source** (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percentage of waiver participants who received services specified in the ISP in accordance with type, scope, amount, frequency, and duration specified in the ISP. Number of waiver participants reviewed (denominator). Number of waiver waiver participants who received services specified in the ISP in accordance with the type, scope, amount, frequency, and duration specified in the ISP (numerator)

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>90% ERROR RATE 15</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percent of new waiver participants whose records have a signed freedom of choice form. Number of new waiver participants reviewed (denominator). Number of new waiver participants whose records have a signed freedom of choice form (numerator)

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		90% ERROR RATE 15
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Percentage of waiver participants with signed ISP documentation of agreements indicating choice of providers and services. Number of waiver participants reviewed

(denominator). Number of waiver participants with signed ISP documentation of agreements indicating choice of providers and services (numerator)

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>90% ERROR RATE 15</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

DHCF has in place several mechanisms to monitor and analyze EPD waiver performance. The LTCA Oversight and Monitoring Division conducts compliance reviews on performance measures of all waiver assurances. The LTCA Oversight and Monitoring Division is responsible for the discovery and remediation process of individual and systemic issues.

On a monthly basis the Division of Quality and Health Outcomes (DQHO) in concert with the LTCA Oversight and Monitoring Division convenes a Quality Management Committee (QMC). The purpose of QMC is to provide oversight of the EPD program to evaluate the performance and implement quality improvement strategies for continuous quality improvement.

Performance measures are derived from the actual EPD waiver measures approved by CMS or other measures that the program feels are important to monitor. A report card of measures is maintained in the DQHO. The EPD staff submits performance rates to DQHO for tracking and trending. Once performance measure rates are submitted to the DQHO, an analysis is completed on individual performance measures and overall program performance.

The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF.

Additionally, DHCF utilizes a work plan that tracks performance and prioritizes improvement efforts and implementation of the Plan-Do-Check-Act quality improvement process. The work plan will be utilized to formally develop the written quality strategy. This strategy will be in compliance with CMS's national initiatives for home and community based settings. This strategy will be aligned with the National Quality Strategy of better care, healthy people, healthy communities, and affordable care. This program will fit within the Agency's strategic mission and strategic goals.

Task 1. The DQHO partners with the LTCA Monitoring and Oversight Division to conduct a comprehensive program evaluation of the previous EPD waiver program. This evaluation will include an analysis of all components of the EPD waiver. It shall include an iterative process for assessing quality performance, identify opportunities for improvement, and outline recommendations for targeted quality improvement processes and measuring and monitoring of the program's overall effectiveness. This evaluation will be completed by April 2017.

Task 2. The program analysis in addition to the work plan will be used to develop a comprehensive five year quality strategy. The quality strategy will include a process for assessing and revising performance measures at least annually.

Task 3. Provisions will be included to ensure that all applicable providers delivering services to waiver participants shall be subject to quality standards, including but not limited to, guidance issued by the Centers for Medicare and Medicaid Services (CMS) and rules issued by DHCF related to quality improvement activities. All applicable service providers shall be subject to quality standards that adhere to CMS and DHCF guidance related to DHCF's EPD quality strategy, and provide for a continuous Quality Assessment and Performance Improvement (QAPI) program consistent with these requirements.

The quality strategy will be completed and implemented by December 2017.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

1) Meeting with providers (individually or as a group) to deliver education to correct the detected problems. This will most often be used for a first time occurrence of a problem of a specific type. Meetings will be conducted by DHCF's Elderly and Persons with Physical Disabilities (EPD) branch. If a problem is detected across multiple providers, DHCF will send an official written transmittal to all providers describing the problem, and how DHCF requires it to be addressed. Documentation of these efforts will be made by DHCF's EPD branch as notes on individual providers, notes on the agenda of monthly provider meeting, or as notes of copies of the transmittals.

2) Problems that recur will be addressed through additional training, and the delivery of a written notice from DHCF requiring the correction of the problem. DHCF's EPD branch is also responsible for written communication with individual providers, and will retain documentation of such communications. 3) Problems that persist will be addressed through more stringent means, including the recoupment of Medicaid payments associated with claims related to the service plan problem. Such recoupments are handled by DHCF's Office of Utilization Management which maintains documentation of all such recoupments. 4) Serious and/or repeated violations of standards for service planning can result in termination of the provider in accordance with DHCF's administrative regulations. Provider terminations are handled by DHCF's Office of Program Integrity which maintains documentation of all such provider actions.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

DHCF or its designee is responsible to review the PCP's using a PCP checklist to ensure that the document contains all the required information prior to the approval of services. The incomplete PCPs are returned to the case manager by DHCF or its designee. Additionally, DHCF's oversight and monitoring selects random PCP's to verify whether the ISP was developed in accordance with the DHCF's PCP guidelines.

All ISPs reviewed must demonstrate that all services are provided in type, scope, amount, description, and frequency in accordance with the ISP. If any of the services is not being received in type, scope, amount, description, and frequency the ISP is marked as non-compliant. A Discovery is generated detailing the deficiency for remediation. As mentioned under question ii (Methods for Discovery), DHCF has in place several mechanisms to monitor and analyze EPD waiver performance. The LTCA Oversight and Monitoring Division conducts compliance reviews on performance measures of all waiver assurances. The LTCA Oversight and Monitoring Division is responsible for the discovery and remediation process of individual and systemic issues.

The District's DQHO has a Program Analyst dedicated to the LTCA and the EPD waiver. This Program Analyst has assisted in development and implementation of an EPD work plan to ensure that all elements of the waiver are in compliance. The Analyst also chairs a Quality Management Committee meeting on a monthly basis that implements the Quality Strategy outline in Appendix H including a Continuous Quality Improvement plan. This process includes the development of Quality Improvement Projects for any assurance that is performing below 86%. All indicators in this assurance have QIPs in place. The District has seen improvements in five (5) of the nine (9) measures within this Assurance and has implemented new interventions in the other four (4). The District anticipates that through this added infrastructure that all performance measure indicators in this Assurance will be in compliance.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

OPPORTUNITIES FOR PARTICIPANT DIRECTION:

All waiver participants have the opportunity to exercise employer authority to recruit, hire, supervise, and discharge qualified participant-directed workers (PDWs) who provide participant-directed community support (PDCS). Financial Management Services (FMS) and Support Broker services are provided as administrative activities by a single, District-wide Vendor Fiscal/Employer Agent (VF/EA) FMS-Support Broker entity selected through a request for proposal (RFP) process.

Waiver participants who choose to enroll in the Services My Way program and self-direct their PDCS have access to all other EPD Waiver services except provider-managed Personal Care Aide (PCA) services. Provider-managed PCA services are considered duplicative of the PDCS services available under the Services My Way program, with the only difference being the service delivery method. Thus, waiver participants may elect to receive either traditional HCBS or participant-directed HCBS or a combination of both. Duplication of services will not occur.

HOW PARTICIPANTS ACCESS PARTICIPANT-DIRECTED SERVICES:

Both current and new waiver participants have the opportunity to elect to enroll in the Services My Way program and self-direct approved PDCS.

Current Waiver Participants –

For current waiver participants, the assigned waiver case manager informs each waiver participant about the program and the opportunity to self-direct approved PDCS using standard, easy-to-understand information approved by DHCF each time a waiver participant is reassessed for services and each time the participant's PCP is updated, if the participant is not enrolled in the Services My Way program, as well as upon the participant's request. All current waiver participants living in their own private residence, or in the home of a family member or friend, have the option to enroll in the Services My Way program and develop a new PCP and a PDS budget that includes PDCS. The waiver case manager will discuss the traditional and participant-directed service delivery options to ensure each waiver participant understands the different opportunities available, their roles and responsibilities, and options for receiving supports.

If a waiver participant wishes to enroll in the Services My Way program, the waiver case manager reviews the requirements of the program with the participant, and develops, with the participant, a revised PCP that includes the participant-directed service option. The case manager sends the revised PCP to the Services My Way Program Coordinator, and the Services My Way Program Coordinator then forwards the PCP to the VF/EA FMS-Support Broker entity. The VF/EA FMS-Support Broker entity assigns a support broker to the waiver participant and commences the enrollment process.

The support broker conducts a comprehensive orientation and training with the waiver participant and the participant's authorized representative, if applicable, using standard, easy-to-understand materials approved by DHCF. The support broker also assists the participant and authorized representative, if applicable, in completing forms and agreements and providing required information as requested in the Participant/Representative Employer Enrollment Packet and PDW Employment prepared and distributed by the VF/EA FMS-Support Broker entity and any other forms and/or agreements, as required by DHCF. Following training and completion of all required documentation, the participant's PDS budget, developed by the participant, the authorized representative, if applicable, and the support broker, is submitted to the Services My Way Program Coordinator for review. Upon approval of the PDS budget, the Program Coordinator issues the appropriate service authorizations and submits the necessary information to the VF/EA FMS-Support Broker entity for enrollment of the participant and the participant's PDW(s) into its system.

New Waiver Participants –

New waiver participants are connected with waiver services through the Aging and Disability Resource Center (ADRC) within the DC Office on Aging (DCOA). Medicaid Enrollment Specialists at the ADRC provide comprehensive options counseling and introduce EPD Waiver applicants to the Services My Way program and participant-directed services using standard, easily understandable information approved by DHCF. If an EPD Waiver applicant expresses an interest in enrolling in the Services My Way program, once the applicant is enrolled in the EPD Waiver and a case manager is assigned, the newly enrolled participant will work with the waiver case manager and support broker as described above for currently enrolled waiver participants.

ENTITIES SUPPORTING INDIVIDUALS:

The VF/EA FMS-Support Broker entity selected through an RFP works with waiver participants enrolled in the Services My Way program to provide support and facilitate their success in self-directing their approved PDCS and managing

their PDS budgets. The VF/EA FMS-Support Broker entity operates in accordance with 26 U.S.C. § 3504 and Rev. Proc. 70-6, as modified by REG-137036-08 and Rev. Proc. 2013-39, and provides both financial management services (FMS) and information and assistance (I&A) services as administrative activities. The scope of FMS and I&A services provided by the VF/EA FMS-Support Broker entity are described in detail in subsequent sections.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.
Select one:

Participant: Employer Authority. As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

Participant: Budget Authority. As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

Both Authorities. The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

Waiver is designed to support only individuals who want to direct their services.

The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

- e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

All waiver participants receive information about using participant-directed services (PDS). As noted above, information regarding PDS is initially provided to new waiver participants by Medicaid Enrollment Specialists at the ADRC, and to current waiver participants by their waiver case managers. For all waiver participants, the waiver case manager documents the participant's choice of service delivery model in the PCP. Waiver case managers also advise participants of their opportunity to change their method of waiver service delivery at any time. Waiver case managers also re-introduce and provide information about PDS to waiver participants each time the participant is reassessed for services and each time the participant's PCP is updated if the waiver participant is not already enrolled in the Services My Way program, as well as upon the participant's request. Information regarding PDS is provided to new waiver participants promptly upon their enrollment in the waiver, in order that the participant has received all information necessary to discuss the Services My Way program with the waiver case manager during the initial meeting to develop the participant's PCP and make an informed decision regarding participation in the program. Information regarding PDS is provided to current waiver participants at each reassessment and each time the PCP is updated, as well as upon the participant's request. Waiver participants may request information regarding PDS at any time and may elect to enroll in the Services My Way program at any time, affording participants sufficient time to make an informed decision regarding participation in the program.

Orientation and training materials provided to participants and their authorized representatives, as appropriate, include, but may not be limited to, details about self-directing their PDS, managing their PDS budget, using FMS and support broker services, being a common law employer, and general Medicaid and non-Medicaid rights and responsibilities. Orientation and training materials specifically include information regarding the potential liabilities associated with being a common law employer of the participant's PDW(s) and with managing the participant's PDS budget.

DHCF has distributed these materials to the Medicaid Enrollment Specialists at the ADRC and to all waiver case managers as part of their PDS training. The materials are also available on the DHCF website. The materials are written to comply with all relevant federal and District standards regarding language access.

The support broker is responsible for providing orientation and training to the participant/representative employer prior to employing a PDW. Initial orientation and training is based upon a standard curriculum developed by DHCF and includes the following:

- Review of the information and forms contained in both the Participant/Representative Employer Enrollment and PDW Employment and Individual-Directed Goods and Services Engagement Packets and how they should be completed;
- The role and responsibilities of the common law employer;
- The role and responsibilities of the VF/EA FMS Division and support broker;
- The process for receipt and processing PDW timesheets and payroll checks;
- The process for purchasing approved individual-directed goods and services from vendors, including submitting invoices for payment;
- Effective practices for recruiting, hiring, training, supervising, managing and firing PDWs;
- The process for resolving issues and complaints; and
- Reviewing workplace safety issues, obtaining workers' compensation insurance coverage and reporting PDW workplace injuries.

In addition, the support broker is responsible for providing ongoing skills training to participants and working with the participant's case manager and VF/EA FMS Division to identify any participants who may need and/or desire additional employer skills training.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The participant may designate an authorized representative to exercise employer-related responsibilities. An authorized representative is a person who is the participant's substitute decision-maker, family member, or any other identified individual who willingly accepts responsibility for performing employer and budget management tasks that a participant is unable to perform him or herself, and includes serving as the common law employer of the participant's PDW(s).

An authorized representative must evince a personal commitment to the participant, be willing to follow the participant's wishes and respect the participant's preferences, while using sound judgment to act in the best interest of the participant. The authorized representative must be actively engaged in the participant's life and live in his or her community. An authorized representative also must execute a Designation of Authorized Representative form.

A participant may only designate one (1) authorized representative at a time, and may revoke an authorized representative designation at any time by notifying the support broker, who will assist the participant to complete the required form. A participant may have one (1) of three (3) types of authorized representative. These include:

Pre-determined Representative – A legal guardian or other court-appointed representative in place at the time of the participant's enrollment in the Services My Way program.

Voluntary Representative – An individual twenty-one (21) years of age or older who is actively engaged in the participant's life and lives in the participant's community.

Mandated Representative – An individual who meets the criteria of a voluntary representative who is designated by the participant if DHCF or its agent determines that the participant requires an authorized representative in order to continue participation in the Services My Way program.

DHCF may determine that a participant requires an authorized representative to continue participation in the Services My Way program if the participant has demonstrated an inability to self-direct his/her services after additional counseling, information, remedial training and/or assistance has been offered by the participant's support broker. If DHCF determines that a participant requires an authorized representative to continue participation in the Services My Way program, DHCF must issue a written notice to the participant, support broker, and waiver case manager, which:

- i. Informs the participant that designation of an authorized representative is required in order to continue participating in the Services My Way program;
- ii. Details the reason(s) that designation of an authorized representative is required;
- iii. Provides instructions on designating an authorized representative; and
- iv. Provides information on the participant's right to appeal the determination by filing a notice of appeal with the Office of Administrative Hearings.

No authorized representative may receive any monetary compensation for serving as a participant's authorized representative for the Services My Way program. An authorized representative may only serve one (1) Services My Way participant, and may not serve as a paid PDW for the participant. All authorized representatives must meet the following requirements:

- i. Effectuate, as much as possible, the decision the waiver participant would make for him/herself;
- ii. Accommodate the participant, to the extent necessary, so he/she can participate as fully as possible in all decisions; and
- iii. Give due consideration to all information including the recommendations of other interested and involved parties.

Waiver participants and authorized representatives are responsible for working collaboratively to ensure that:

- i. Waiver participants receive needed PDCS from qualified PDWs; and
- ii. PDCS services and individual-directed goods and services are provided in accordance with the participant's PCP and PDS budget.

The following safeguards are in place to ensure that an authorized representative functions in the best interests of the participant: Authorized representatives are required to complete and sign an Authorized Representative Designation Form, which includes attestations that the authorized representative will make decisions in the participant's best interest, has not been convicted of a felony, and will attend initial orientation and ongoing

training as required by DHCF. The performance of authorized representatives will be continually monitored by the participant's support broker and waiver case manager, either of whom may alert the Services My Way Program Coordinator if there is a concern regarding whether the authorized representative is acting in the participant's best interest. PDWs may also alert the participant's support broker or waiver case manager with any concerns regarding an authorized representative's performance.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Participant-Directed Community Support Services		
Individual Directed Goods and Services		
Personal Care Aide		

Appendix E: Participant Direction of Services

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h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

Yes. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

FMS are provided to all waiver participants enrolled in the Services My Way program by a singleone, District-wide, qualified VF/EA FMS-Support Broker entity, selected through a competitive procurement process (RFP).

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The VF/EA FMS-Support Broker entity receives a per participant per month administrative fee for the financial management services provided that is established through the competitive procurement process. The selected vendor must apply the per participant per month fee consistently for each participant actively enrolled with the vendor.

The VF/EA FMS-Support Broker entity receives a separate per participant per month administrative fee for the support broker service provided by the VF/EA FMS-Support Broker entity, established through the competitive procurement process. The selected vendor must apply the per participant per month fee consistently for each participant actively enrolled with the vendor.

The VF/EA FMS-Support Broker entity receives a separate one-time set-up fee for enrolling the participant/representative employer with the VF/EA FMS-Support Broker entity. The one-time set-up fee is consistent for each participant/representative employer.

The VF/EA FMS-Support Broker entity receives a separate one-time set-up fee for enrolling a qualified PDW in its PDW payroll system. The one-time set-up fee is consistent for each PDW.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

Specify:

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement

with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

Supports furnished when the participant is the employer of direct support workers:

Assists participant in verifying support worker citizenship status

Collects and processes timesheets of support workers

Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

Specify:

The VF/EA FMS/Support Broker entity operates in accordance with 26 U.S.C. §3504 and Rev. Proc. 70-6, as modified by REG-137036-08 and Rev. Proc. 2013-39, as well as applicable federal and District labor, citizenship and immigration, and workers' compensation requirements. The entity offers the following FMS:

- Obtaining federal and District approval to perform as a VF/EA (e.g., filing and submission of IRS Forms 2678 and 8821, and DC powers of attorney for income tax and unemployment tax filing and payments);
- Preparing and maintaining a DC-specific VF/EA FMS-Support Broker Policies and Procedures Manual that includes written policies, procedures and internal controls for all VF/EA FMS and Support Broker tasks and updating it as needed and at least annually;
- Staying up-to-date with all federal and state program, labor, employment tax and workers' compensation insurance requirements related to participant/representative employers, their PDWs, and VF/EA FMS;
- Developing a transition plan for when/if the VF/EA FMS – Support Broker entity changes to facilitate the transition process and in accordance with DHCF requirements;
- Receiving and disbursing Medicaid funds and monitoring any balances;
- Submitting claims for Medicaid reimbursement for PDCS and individual-directed goods and services rendered;
- Submitting invoices to DHCF for VF/EA FMS and Support Broker administrative fees;
- Providing customer service (i.e., toll free phone and TYY numbers and informational materials that comply with all federal and District standards regarding disability and language access) per DHCF requirements;
- Preparing and distributing Participant/Representative-Employer Enrollment Packets;
- Collecting and processing the completed forms, agreements and information requested in the Participant/Representative-Employer Enrollment Packets;
- Preparing and distributing the PDW Employment and Individual-Directed Goods and Services Vendor Engagement Packets;
- Collecting and processing the completed forms, agreements and information requested in the PDW Employment and Individual-directed Goods and Services Vendor Engagement Packets;
- Enrolling participant/representative employers with the VF/EA FMS-Support Broker entity;
- Enrolling PDWs in the VF/EA FMS-Support Broker entity's payroll system;
- Verifying that criminal background checks are conducted on all prospective PDWs;
- Reporting PDWs in the DC New Hire Reporting System;
- Assisting participant/representative employers with determining citizenship and legal alien status by processing the US CIS Form I-9;
- Collecting and processing PDWs' timesheets in accordance with a participant's PCP and PDS budget;
- Processing PDW payroll including paying wages in compliance with the DC Living Wage Act and filing and paying federal and District of Columbia required taxes;
- Processing garnishments liens and levies against PDWs' wages;
- Processing end-of-year federal and state tax activities including IRS Forms W-2, FICA refunds, and DC tax reconciliations, as required;
- Receiving and processing invoices from individual-directed goods and services vendors for payment;
- Processing returned payments (i.e. payroll checks or payments to individual-directed goods and services providers) in accordance with the District's Unclaimed Property Law;
- Managing the receipt and renewal of workers' compensation insurance policies for waiver participant/representative-employers;
- Establishing and maintaining current and archived records and files in a confidential and secure manner and for required time period;
- Implementing and testing a disaster recovery plan for electronic data and files;
- Preparing and submitting DHCF required reports; and

- Executing Medicaid provider agreements for PDWs and individual-directed goods and services vendors as authorized under a written agreement with the Medicaid agency and maintaining them on file.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

DHCF monitors and assesses the readiness and ongoing performance of the VF/EA FMS-Support Broker entity through a number of monitoring activities. DHCF conducted an on-site readiness review of the VF/EA FMS-Support Broker entity prior to the contract award. DHCF also conducts an annual VF/EA FMS-Support Broker Entity Quality Assessment and Performance Review using the methods described in Appendix A (5) and (6). The VF/EA FMS-Support Broker entity is required to prepare and submit monthly utilization and expenditure reports to DHCF. DHCF's Office of Contracts and Procurement (OCP), in collaboration with the Health Care Delivery Management Administration's (HCDMA) Division of Quality and Health Outcomes (DQHO), will address other quality assurance related issues as they arise.

DHCF conducts a participant/representative employer satisfaction survey on an annual basis. DHCF analyzes the survey results and includes them in the VF/EA FMS-Support Broker entity annual performance review.

Furthermore, the integrity of financial transactions performed by the FMS is ensured through inclusion of Services My Way participants in the quarterly compliance reviews conducted by the EPD Waiver oversight and monitoring team, as discussed in Appendix I.

The scope of this post-payment review process is as follows: Data is selected for review by identifying beneficiaries at random from the list of Services My Way participants, such that at least ten percent (10%) of the beneficiaries included in the review are Services My Way participants. The frequency of this post-payment review process is quarterly. The methodology used to ensure the integrity of payments made by the VF/EA FMS-Support Broker entity is as follows: MMIS paid claims to the VF/EA FMS-Support Broker entity are compared to PDW timesheets signed by participant/representative-employers during the quarter under review. If discrepancies between the paid claims and signed timesheets are found, the VF/EA FMS-Support Broker entity and the participant/representative-employer(s) are notified, and a referral is made to DHCF's Division of Program Integrity for investigation. In addition to the quarterly reviews conducted to ensure compliance with the EPD Waiver program's performance measures, the VF/EA FMS-Support Broker entity is included as an EPD Waiver provider in the oversight and monitoring team's annual oversight and monitoring review, as discussed in Appendix I.

Appendix E: Participant Direction of Services

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j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case management services facilitate coordination of all waiver services, including participant-directed services, provided to participants so that services are delivered in a well-coordinated, safe, timely and cost-efficient manner that addresses the participant's specific needs. Case management services for all waiver participants are detailed in Appendix D. In addition to all responsibilities detailed in Appendix D, a participant's waiver case manager performs the following information and assistance tasks related to PDS:

- Conducts initial outreach and education on the Services My Way program for waiver participants using standard outreach and PDS information materials, and documents the participant's decision on whether or not to use PDS.
- Re-introduces the Services My Way program to waiver participants not enrolled in PDS each time the participant's PCP is updated, each time the participant is reassessed, and upon the participant's request.
- Identifies waiver participants' desired outcomes for using PDS under a person-centered planning process and includes PDS in the participant's PCP.
- Provides copies of the participant's updated and approved PCP and authorized representative, as appropriate, the waiver participant's support broker, and the Services My Way Program Coordinator.
- Monitors participant/representative employer performance in using PDS in collaboration with the participant's support broker.
- Participates in the Remediation, Training and Termination process with the Services My Way Program Coordinator, VF/EA FMS Division, support broker and other entities, as appropriate.
- Assesses participants' and representatives', as appropriate, receipt of and satisfaction with PDS in collaboration with the participant's support broker.

Waiver Service Coverage.

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Participant-Directed Community Support Services	
Chore Aide	
Individual Directed Goods and Services	
Respite	
Assisted Living	
Case Management	
Adult Day Health	
Environment Accessibility and Adaptation Services	
Homemaker	
Community Transition Services	
Personal Care Aide	

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

The Support Broker Division of the VF/EA FMS-Support Broker entity furnishes information and assistance (I&A) supports to participants enrolled and their representatives as appropriate. As detailed above, the VF/EA FMS-Support Broker entity will receive a consistent per participant per month fee for support broker services. A waiver participant's support broker furnishes the following I&A supports related to PDCS and individual-directed goods and services:

- Provides initial orientation and skills training to participants and authorized representatives, as appropriate, on using the Services My Way program, self-directing their PDS and managing their PDS budget, using FMS and support broker services, being a common law employer, and general Medicaid and non-Medicaid rights and responsibilities.
- Provides ongoing skills training to participants and authorized representatives, as appropriate, on using the Services My Way program, self-directing their PDS and managing their PDS budget, using FMS and support broker services, being a common law employer, and general Medicaid and non-Medicaid rights and responsibilities as needed.
- Assists participant/representative employers in completing the forms and agreements included in the Participant/Representative-Employer Enrollment Packet and Participant-directed Worker (PDW) Employment and Individual-Directed Goods and Services Vendor Engagement Packet.
- Assists participant/representative employers in developing, implementing, monitoring effectiveness and revising, as needed, emergency back-up and natural support plans and designated emergency back-up staff and natural supports.
- Assists waiver participants in designating an authorized representative, as necessary, assessing effectiveness of the authorized representative and selecting a new authorized representative if needed.
- Develops, with the participant and authorized representative, as appropriate, the participant's PDS budget for approval by the Services My Way Program Coordinator.
- Updates, with the participant and authorized representative, as appropriate, the participant's PDS budget and submits the revised budget for approval by the Services My Way Program Coordinator.
- Develops with the participant and his/her representative, as appropriate, proposals to reallocate PDS budget funds from labor to individual-directed goods and services or vice versa and submits them for approval by the Services My Way Program Coordinator.
- Assists the participant and authorized representative, as appropriate, in tracking PDS expenditures in accordance with the participant's PDS budget.
- Assists participants and authorized representatives, as appropriate, in making decisions about purchasing individual-directed goods and services.
- Assists participants and authorized representatives, as appropriate, in resolving issues as they arise.
- Conducts periodic in-home visits and phone calls with participants to monitor that their PDS is being provided in accordance with the participant's PCP and PDS budget, their health and safety and to answer questions or concerns.
- Assesses effectiveness of participant's authorized representative and suggests modification, as needed.
- Assesses effectiveness of participant/representative employer's emergency PDW backup plan and designated staff and suggests modifications, as needed.
- Assesses effectiveness of participant/representative employer's natural supports plan and delegated natural supports and suggests modifications, as needed.
- Reports critical incidents as a mandatory reporter.
- Participates in the Remediation, Training and Termination process with Services My Way Program Coordinator, waiver case manager, VF/EA FMS Division, and other entities, as appropriate.

As noted above, DHCF conducts an annual VF/EA FMS-Support Broker Entity Quality Assessment and Performance Review. All quality assessments and performance reviews of the VF/EA FMS-Support Broker entity include the I&A services described above. DHCF also conducts participant/ representative employer satisfaction surveys on an annual basis. The surveys address satisfaction with the I&A services described above.

Appendix E: Participant Direction of Services

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k. Independent Advocacy (*select one*).

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

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l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Waiver participants have the option to transition from participant direction to the provider- managed service delivery model at any time. This is accomplished by the participant completing the Voluntary Participant Termination Notice and sending it to the Services My Way Program Coordinator for processing. The Program Coordinator will then inform the participant's support broker and waiver case manager of the participant's decision. The waiver case manager will then guide the waiver participant through the transition process and be responsible for transitioning the waiver participant to the traditional model of service. The waiver case manager will ensure there is no break in service during the transition period and coordinate the approval by DHCF or its designee of the request to initiate agency-based personal care aide services.

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m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Remediation, Training and Termination Protocol

DHCF has developed a remediation, training and termination protocol for participant/ representative-employers who fail to comply with the terms of the Participant/Representative Employer Agreement. Non-compliance with the Participant/ Representative Employer Agreement may be discovered by the VF/EA FMS-Support Broker entity, the participant's support broker, the waiver case manager, or DHCF staff.

Participant/representative-employers are generally allowed three (3) episodes of non-compliance related to each employer-related responsibility delineated in the Participant/ Representative Employer Agreement during the first twelve (12) month period of enrollment in the Services My Way program. This will allow new program participants to become familiar with all employer-related responsibilities and provide an opportunity for additional training and support where required as participants adjust to the program terms. Thereafter, participant/ representative-employers are allowed a further three (3) episodes of non-compliance related to any employer-related responsibility delineated in the Participant/Representative Employer Agreement for the remainder of their enrollment in the Services My Way program. The third episode of non-compliance necessitates the participant's termination from the Services My Way program and transition to agency-based personal care aide services.

First Episode of Non-Compliance. When a participant/representative-employer is found to be out of compliance with the Participant/Representative Employer Agreement for the first time, the following steps occur:

A. The Services My Way Program Coordinator issues a notice of non-compliance to the participant/representative-employer, the support broker, and the waiver case manager, which:

- i. Identifies the issue of non-compliance and requests that the issue be corrected (if possible), and not repeated;
- ii. Details requirements of the Corrective Action Plan (CAP) the participant will create to address the issue;
- iii. Offers training and/or technical assistance;
- iv. Encourages the participant/representative employer to direct questions to the support broker, including requesting training, obtaining assistance in preparing the CAP, and designating an authorized representative;
- v. Identifies consequences of further non-compliance with the Participant/Representative Employer Agreement; and
- vi. Provides details on the participant's appeal rights for termination from the program, should three (3) episodes of non-compliance occur.

B. Within five (5) business days of issuing the notice of non-compliance, the support broker contacts the participant/representative-employer to discuss the episode of non-compliance.

C. Within five (5) business days of the above-mentioned contact, the participant, with the assistance of the authorized representative and/or the support broker, if needed, draft and sign a written CAP regarding the episode of non-compliance.

i. The support broker provides copies of the signed CAP to the waiver case manager and the VF/EA FMS-Support Broker entity.

ii. The support broker is responsible for monitoring the CAP. If the participant or authorized representative, as applicable, fails to implement all or a portion of the CAP, this is considered an episode of non-compliance and is reported to the Services My Way Program Coordinator.

Second Episode of Non-Compliance. When a participant/representative-employer is found to be out of compliance with the Participant/Representative Employer Agreement for a second time, the following steps occur:

A. The Services My Way Program Coordinator issues a second notice of non-compliance to the participant/representative-employer, the support broker, and the waiver case manager, which contains all the information detailed above for the initial notice of non-compliance.

B. Within five (5) business days of issuing the second notice of non-compliance, the support broker contacts the participant/representative-employer to discuss the episode of non-compliance.

C. Within five (5) business days of the above-mentioned contact, the participant, with the assistance of the authorized representative and/or the support broker, if needed, draft and sign a written CAP regarding the episode of non-compliance. As detailed above, the support broker is responsible for monitoring the CAP, and failure to implement all or a portion of the CAP is considered an episode of non-compliance.

Third Episode of Non-Compliance. When a participant/representative-employer is found to be out of compliance with the Participant/Representative-Employer Agreement for a third time, the following steps occur:

A. The Services My Way Program Coordinator issues a termination notice to the participant/representative-employer, the support broker, and the waiver case manager, which:

- i. Identifies the three (3) episodes of non-compliance;
- ii. Clearly states that DHCF is terminating the participant's enrollment in the Services My Way program, per notice provided in the first and second notices of non-compliance;
- iii. Informs the participant that he/she will be transitioned to agency-based personal care aide services, per notice provided in the first and second notices of non-compliance; and
- iv. Provides information regarding the participant's right to appeal the Services My Way program termination decision by filing a notice of appeal with the Office of Administrative Hearings.

B. Within five (5) business days of issuing the termination notice, the support broker contacts the participant/representative-employer and addresses the following topics:

- i. Reference to the first and second notices of non-compliance and the termination notice;
- ii. Review of the consequences of three (3) episodes of non-compliance;
- iii. Explanation of the process to transition the participant to agency-based personal care aide services; and
- iv. Explanation of the participant's right to appeal the Services My Way program termination decision and the appeal process.

Credible Allegations of Fraud, Theft, or Other Criminal Behavior

In the case of a credible allegation of fraud, theft, or any other criminal behavior committed by a Services My Way participant, the participant is not referred to the remediation, training and termination protocol, and is not afforded three (3) episodes of non-compliance. The participant may be terminated from the program immediately upon completion of an investigation by the DHCF Division of Program Integrity substantiating the credible allegation of criminal behavior.

A. If the DHCF Division of Program Integrity receives a credible allegation of fraud, theft, or any other criminal behavior by a Services My Way participant, the Division completes an investigation of the allegation and issues a report detailing its findings. If the report finds the allegation to be substantiated, DHCF then convenes a termination committee comprised of staff from multiple divisions as well as executive management to review the report and determine whether to terminate the participant based on the findings documented in the report.

B. If a participant is terminated from the program under these circumstances, the Services My Way Program Coordinator sends a termination notice to the participant/representative-employer, the support broker, and the waiver case manager, which:

- i. Clearly states that DHCF is terminating the participant's enrollment in the Services My Way program, due to a substantiated allegation of fraud, theft or other criminal behavior;
- ii. Explains the allegation, the investigation process, and the findings of the investigation, and includes a copy of the investigation report;
- iii. Explains the process to transition the participant to agency-based personal care aide services, if appropriate; and
- iv. Provides information regarding the participant's right to appeal the Services My Way program termination decision by filing a notice of appeal with the Office of Administrative Hearings.

If a participant files a notice of appeal with the Office of Administrative Hearings within thirty (30) days of the date on the termination notice, the participant remains enrolled in the Services My Way program and continues to receive PDCS services and individual-directed goods and services included in the participant's approved PDS budget while the appeal is pending.

Transition Safeguards

The following safeguards are in place to ensure continuity of services and protect participant health and welfare during the transition: The transition to agency-based personal care aide services only occurs following receipt and explanation of the termination notice and the completion of any ensuing appeal of the termination decision. Within five (5) business days of issuing the termination notice, the support broker contacts the participant to discuss the process for transitioning to agency-based personal care aide services with support from the waiver case manager. As in the case of voluntary termination, the waiver case manager is responsible for guiding the participant through the transition process and for coordinating the approval of the request to initiate agency-based personal care aide services. The waiver case manager ensures there is no break in service and monitors participant health and welfare during the transition.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	<input type="text"/>	<input type="text" value="160"/>
Year 2	<input type="text"/>	<input type="text" value="180"/>
Year 3	<input type="text"/>	<input type="text" value="200"/>
Year 4	<input type="text"/>	<input type="text" value="220"/>
Year 5	<input type="text"/>	<input type="text" value="240"/>

Appendix E: Participant Direction of Services**E-2: Opportunities for Participant Direction (1 of 6)**

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

Recruit staff

Refer staff to agency for hiring (co-employer)

Select staff from worker registry

Hire staff common law employer

Verify staff qualifications

Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

Each potential PDW completes and pays for the combined FBI and District of Columbia criminal background check. Completing and passing the combined criminal background check is a condition of employment as a PDW. The criminal background check will be facilitated by the VF/EA FMS Division. If a PDW does not pass the required criminal background check, the participant/representative employer and the Services My Way Program Coordinator are notified.

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Benefits to PDWs include the payment of Medicare and Social Security taxes (FICA), federal and state unemployment insurance taxes, and workers compensation insurance coverage, as well as any other benefits specifically required by DC or federal law as of the effective date of this renewal.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

--

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The participant-directed services (PDS) budget is developed based on the following methodology:

- (1) A PCP is developed based on the results of a comprehensive assessment for long term care services and supports using a standard tool. The process for PCP development is the same for all waiver participants, regardless of service model.
- (2) Then, the total assessed hours per week for PDCS is determined and converted to hours per month.
- (3) Then, total PDCS hours per month are multiplied by the traditional rate of payment for PCA services.
- (4) The total amount computed in Item 3 is then reduced by a pre-determined percentage to reflect the administrative overhead amount in the traditional PCA rate.
- (5) The resultant amount represents the participant's PDS monthly allocation amount, which will be used to compute his/her PDS budget.

The participant's PDS budget is developed by the participant/representative-employer and the support broker by executing the following steps:

- (1) The PDS budget contains two cost components: PDCS labor and individual-directed goods and services.
- (2) The participant determines the wage rate paid to the PDW(s) based on the wage range prescribed by DHCF, which shall be no less than the DC living wage and no more, including employment taxes and insurance amounts, than the current rate paid for agency-based personal care aide services.
- (3) Individual-directed goods and services will be determined based on available funds remaining in the PDS budget after the PDCS budget amount is determined. This methodology will be used to determine PDS budgets for all participants.

The Services My Way Program Coordinator provides the participant's PDS monthly allocation amount, calculated using the methodology described above, to the participant/representative-employer and the support broker. The participant/representative-employer then works with the support broker to determine how the PDS budget will be developed to best serve the participant's needs while maintaining health and welfare.

The support broker submits the PDS budget to the Services My Way Program Coordinator, who must approve all PDCS and individual-directed goods and services requested in the budget. Once approved, the PDS budget is provided to the VF/EA FMS-Support Broker entity, which must pay PDWs for approved PDCS services rendered and invoices from vendors for approved individual-directed goods and services in accordance with the PDS budget.

Information about the PDS budgeting process is available through the outreach and training materials provided by DHCF and its agents and is accessible to the public via the DHCF website.

Support Broker entities are described in detail in subsequent sections.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

- iii. **Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

As detailed above, the Services My Way Program Coordinator provides the PDS monthly allocation amount to the participant/representative-employer and the support broker, who then develop a detailed PDS budget based on the monthly allocation amount.

If the participant's needs change at any time, the participant, with assistance from the support broker and authorized representative, if applicable, may request an adjustment to the PDS budget. The Program Coordinator will provide the participant, the support broker, and the authorized representative, if applicable, with written notice of the approval or denial of the request. If the participant disagrees with the Program Coordinator's determination, the participant may request a redetermination of the request. The participant also has the right to appeal the determination by filing a notice of appeal with the Office of Administrative Hearings.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one:*

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

DHCF has implemented a number of safeguards to prevent the premature depletion of the PDS budget and address potential service delivery problems that may be associated with budget underutilization.

(1) The VF/EA FMS Division prepares and issues a monthly PDS budget report to participant/representative-employers, support brokers, waiver case managers, and the Services My Way Program Coordinator. This report provides the PDS budget amount, services used, and expenditures incurred for the current month and year to date, as well as the remaining balance. The support broker reviews this report with the participant/representative-employer as needed and addresses any questions.

(2) The VF/EA FMS Division monitors PDCS utilization by pay period. The VF/EA FMS Division issues a report to the participant/representative employer, the support broker, the waiver case manager and the Services My Way Program Coordinator if significant over- or under-utilization of PDCS services is found. The support broker reviews the report with the participant/representative employer and addresses any questions. If over-utilization of PDCS services is found, the VF/EA FMS Division collects the amount of the overage from the participant/representative-employer. Significant over-utilization of PDCS services is considered an episode of non-compliance with the terms of the Participant/Representative-Employer Agreement and results in referral of the participant/representative-employer to the remediation, training and termination protocol detailed above, which requires the participant/representative employer to prepare a CAP detailing how the participant/representative employer will remedy the issue.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the

request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The beneficiary freedom of choice form specifies that the beneficiary has the right to choose to reside in an institutional setting or a home and community based setting. It is also documented in the form that the beneficiary has the right to choose which provider to use. A list of current approved providers is given to the beneficiary or significant other to choose from.

Any applicant/beneficiary for the EPD Waiver program aggrieved by DHCF's action or inaction which affects his/her participation in the EPD Waiver program or the level of benefits received under the EPD Waiver program may request a fair hearing. During the application and recertification process for the EPD Waiver, the Economic Security Administration (ESA) sends written notice of the eligibility determination to applicants/beneficiaries on a standard form which contains an explanation of the applicant/beneficiary's right to request a fair hearing regarding his/her EPD Waiver eligibility. In addition, applicants/beneficiaries are provided with the process for requesting such a hearing, the right to present witnesses, the right to be represented by legal counsel or other spokespersons of choice, the right to have reasonable expenses related to the hearing paid by the District of Columbia Government, and that legal services are available to the applicant/beneficiary.

All applicants/beneficiaries enrolled in the EPD Waiver program may request a fair hearing when their EPD Waiver services are denied, suspended, reduced, or terminated. A hearing request is an expression, oral or written, by the applicant/beneficiary or his/her representative that:

- The applicant/beneficiary wishes to appeal a decision of DHCF; and
- The applicant/beneficiary wants an opportunity to present his/her case at the Office of Administrative Hearings (OAH).

The request for a hearing must be filed within 90 days of the date of the notice to either OAH or the Office of Health Care Ombudsman. The request for a hearing may be made verbally or in writing.

All applicants will be afforded the right to request a hearing if they are not notified of a decision on their application for the EPD Waiver Program within the time allowed. In addition, at any time during the certification period, a beneficiary may request a fair hearing to dispute his current level of benefits under the EPD Waiver Program.

If the applicant/beneficiary requests a fair hearing before the effective date of the proposed adverse action, services under the EPD Waiver program must be continued at the previous level unless the applicant/beneficiary specifically waives continuation of services under the EPD Waiver program. DHCF shall implement the adverse action during the appeal only if the applicant/beneficiary requests in writing that the adverse action be allowed to take effect pending the outcome of the appeal. DHCF shall not permit the adverse action to become effective if the following criteria are met:

The recipient requests the fair hearing before the effective date of the adverse action or within 15 days of the postmark date on the notice of adverse action and/or whichever is later. Medical assistance shall be continued at the previous level unless the recipient specifically waives continuation of Medical assistance. DHCF shall implement the adverse action, only if a recipient requests in writing that the adverse action be allowed to take effect pending the outcome of the appeal.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a)

the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The Department of Health Care Finance (DHCF)s Long Term Care Administration (LTCA), Elderly Persons with Physical Disabilities Branch (EPPDB) is responsible for the operation of the grievance/complaint system. Additionally, the District of Columbia Office of the Health Care Ombudsman and Bill of Rights (OHCOBR), an independent office located in the District of Columbia DHCF operates a separate complaint resolution system, to which waiver participants may also make complaints. DHCFs Health Care Division Management Administration (HCDMA) that includes the Long Term Care Administration (LTCA) have standing bi-weekly meetings with OHCOBR to coordinate on the resolution of all types of complaints including those pertaining to all of long term care including those related to this waiver, and to facilitate the development of program improvements to address underlying systemic issues that may have lead to the complaint.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) Participants may make all types of complaints or grievances to the LTCA pertaining to the denial or provision of waiver services. These include, but are not limited to, complaints about: denial or reductions of service; the process or results of their waiver eligibility determination; poor timeliness or quality of care; restriction of their rights; lack of or interference with choice of provider; issues related to the waiver waiting list; patient abuse, neglect, or exploitation by waiver providers; and violations of patient privacy or confidentiality. All complaints about abuse, neglect, or exploitation by waiver providers will follow the EPD Waiver Incident Management process.

(b) The timelines for resolving complaints are as follow- All complaints that indicate that a beneficiary's health and/or welfare are at immediate risk are addressed within 24 hours or next business day of the receipt of the complaint. Complaints pertaining to Medicaid eligibility determination and denial or reduction of service are addressed within five seven (7) business days; all other complaints are addressed within ten business days and resolved within thirty (30) days of the receipt of the complaint. If the complaint remains unresolved after the third week, it is forwarded to Project Manager of the EPPDB for his/ her intervention. If after thirty (30) days the complaint remains unresolved, it is forwarded to the Project Manager for the Division of Long-Term care for his/ her intervention. Complainants are also informed upon the initiation of the complaint of the right to a fair hearing and how to obtain one.

(c) When a beneficiary or advocate authorized by the beneficiary contacts the LTCA, the complaint is documented and logged into Complaints Log system and assigned to one of several staff persons in the LTCA for investigation and resolution. These staff investigate and use a variety of processes and mechanisms to resolve the complaint, depending upon the nature of the complaint. These processes and mechanisms include, but are not limited to: interviewing the beneficiary, beneficiary representative, service provider, and others with knowledge of the problem to obtain a clear understanding of the problem; reviewing the beneficiary's service records and provider documentation; and reviewing billing records. Once the problem is well understood, staff can take a number of actions as appropriate including: directing the provider to develop (to be approved by staff in the LTCA and implement a corrective action; assisting the beneficiary to choose another provider and transfer to that provider; referring the situation to Adult Protective Services; referring the situation to the DHCF Division of Program Integrity when instances of provider fraud or abuse are suspected; and referring complainants to the fair hearing process when certain complaints are not addressed to their satisfaction or involve issues pertaining to eligibility for or denial of services. The LTCA informs all complainants that filing a grievance or complaint is not a prerequisite for a fair hearing, and informs the complainant of his or her right to request a fair hearing if: the request for Medicaid eligibility is denied or not acted upon promptly; Medicaid eligibility is terminated or suspended; or the complainant believes a request for a service has been wrongfully denied, reduced, or not acted upon promptly.

The OHCOBR is comprised of two legislative requirements, the Ombudsmans Program (D.C. Code § 7-2071.01 et seq.), and the Grievance Procedures for Health Benefit Plans (D.C. Code § 44-301.01 et seq.). In February, 2008, the D.C. Medical Assistance Administration of the D.C. Department of Health (DOH) became a separate, cabinet-level agency, DHCF, for the administration of the Medicaid program (D.C. Code § 7-771.01 et seq.) and obtained jurisdiction over matters pertaining to both requirements. These laws, regulations, and policies pertaining to complaints and grievances are available to CMS upon request.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The District recognizes two categories of incidents: serious reportable and reportable incidents. A Serious Reportable Incident (SRI) is a significant event or situation which due to its severity requires immediate response, notification to, and internal review and investigation by the provider agency and/or the DHCF. SRIs include, but are not limited to: death; abuse; neglect; exploitation; theft of consumer personal property; serious physical injury; inappropriate or unauthorized use of restraints; suicide attempt; and serious medication error. A Reportable Incident (RI) is a significant event or situation involving a participant and shall be reported to the DHCF, and investigated by the provider. RIs include, but are not limited to: medication error; missing person; hospitalization; suicide threat; vehicle accident; fire; police; emergency room visit; emergency relocation; property destruction; and, other events or situations that involve harm or risk of harm to a participant.

All employees, sub-contractors, consultants, volunteers or interns of an Elderly Persons with Disability (EPD) provider agency or government agency are required to notify the DHCF within 5 business days of occurrence, when a serious reportable incident or reportable incident is witnessed, discovered or becomes know. Notifications are made via facsimile or reported electronically through the DHCF's EPD electronic case management system. Casenet is the DHCF's case management tracking system. All case management providers are required to electronically report incidents.

In the event of a serious reportable or reportable incident the provider is required to document the incident on its internal incident report form and complete an internal investigation within five business days of the incidents occurrence. Furthermore, the provider is required to submit all incident report forms to the Long Term Care Administration.

Additionally, for all serious reportable incidents involving death, neglect, abuse and theft of consumer personal property, occurring at a participant (s) natural home the provider is required to report the incident to the DHCF and the District of Columbia, Adult Protective Services (APS). Deaths that are expected and/or of natural causes are not required to be reported to APS.

With the exception of case management agencies, for all serious reportable and reportable incidents the provider is required to report the incident to the DHCF and the District of Columbia, Department of Health/Health Regulation and Licensing Administration (DOH/HRLA). Case management agencies are not licensed by DOH/HRLA, therefore, are not required to report incidents to that entity. Further, all serious incidents involving death or criminal activity which occurs at an assisted living facility are reported by the provider to the District of Columbia, Metropolitan Police Department (MPD). These incidents include, but are not limited to abuse or theft of consumer property.

Incident data reported to the DHCF is entered and tracked on an internal complaint log maintained by staff in the DHCF's Elderly Persons with Physical Disabilities Branch (EPPDB) and aggregated by the DHCFs, Division of Quality and Health Outcomes (DQHO) for trends. Additionally, DQHO generates quarterly and ad hoc quality reports on incident management data as part of the Districts quality improvement efforts.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Training and information are offered to participants and or families or legal representatives in the following manner: All participants and their family members/legal representatives are provided with information about the EPD Waiver including the protections and safeguards that are afforded them.

The District is formulating an incident management policy that will recommend to the EPD waiver providers best practices to follow in the area of incident reporting and investigating, to include how to identify and report abuse, neglect and exploitation. Providers shall develop an internal protocol to ensure compliance with this policy. The protocol shall establish procedures, to include the responsibilities of employees, interns, volunteers, consultants and contractors with regard to identifying, reporting, investigating, addressing and monitoring the follow-up of incidents.

On an annual basis, EPD waiver providers are required to train and educate participants regarding abuse, neglect, mistreatment and exploitation, and as part of enhanced quality expectations are expected to use naturally occurring opportunities throughout the year to reinforce the learning process.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Incident Management refers to the reporting and prevention of abuse, neglect, and exploitation of participants served in Medicaid-funded, home and community-based service programs. Incident Management also includes the reporting of participant involvement with law enforcement or emergency services; the reporting of environmental hazards that compromise the health and safety of a participant; and reporting the death of a participant.

The DHCFs EPPDB ensures that all incidents submitted by the provider are adequately completed within 24 hours or the next business day, of the incident being reported to the DHCF. When necessary, the designated staff in the EPPDB contacts the provider to ensure that required notifications were made. The designated staff also verifies that all serious reportable incidents involving allegations of abuse, neglect, exploitation and theft of consumer personal property, where staff was alleged to be involved in the incident have been removed from contact with the participant until receipt by the DHCF of a satisfactory investigation from the provider.

All serious reportable incidents are investigated by the provider, submitted to the DHCF and reviewed by the DHCFs EPPDB to determine the need for additional follow up/remediation, or the need for an investigation by the EPPDB. Reportable incidents are written on an incident report form, investigated by the provider and the investigation report is maintained on the provider site and made available to all pertinent DHCF employees.

Follow up/ remediation action requested by the DHCF in response to an investigation is to be implemented within ten business days of receipt of notice from the DHCF. Any follow up/remediation action not addressed by the provider after receiving notice must be supported and acceptable by the DHCF. Further, when a provider fails to address follow up/remediation action the DHCF will recommend that the involved participant selects an alternate provider. Additional remediation action may be initiated by DOH/HRLA.

The provider must report the outcome of an investigation to the participant. Timeframes for informing the participant of the investigation results are done within one business day of completion of an investigation.

Timeframes for reporting an incident can be changed or adjusted when there are health and safety concerns that require immediate response.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

On a quarterly basis, the EPPDB submits its complaint log and other incident management data to the DQHO who conducts an analysis of data collected as part of the incident management process. The DQHO evaluates trends of incident data and present findings to EPPDB for needed follow up with the provider.

Quarterly reports of incident management trends and findings are prepared for dissemination and review by the Districts steering committee which has responsibility for monitoring performance of all EPD waiver providers. The oversight and monitoring team will review the reported incidents on a monthly basis to identify individual and provider patterns/trends and to ensure that providers are managed as per DHCF's policy and procedures. The LTCA staff from oversight and monitoring team will generate a discovery to the provider and follow up for resolution. Additionally, the oversight and reporting team analyze the incident tracking on a quarterly basis and make recommendations to the operations division for systemic improvement on incident management. Additionally, DHCF will provide training to provider agencies during provider leadership meetings.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The District of Columbia Assisted Living Residence Regulatory Act of 2000 (ALR) prohibits the use of restraints and restrictive interventions in Assisted Living Facilities. In addition, ALR also references the sanctions and remedies which are outlined in the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983. The Department of Health Regulatory Licensing Agency (DOH HRLA) monitors Assisted Living facilities for use of restraints and/or other restrictive interventions. Oversight is conducted via routine annual surveys, surveys triggered by complaints or incidents, and more frequently when deficient practices are detected, as stipulated in the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983. Interviews also occur with patients, family, direct care staff, health care delivery teams. Reviews are conducted more frequently based on severity and frequency of complaints.

Any detected violations of the prohibition on use of restraints and restrictive interventions in Assisted Living Facilities are reported to the state Medicaid agency. Although this occurs at present via informal procedures, as part of implementing this waiver the state Agency will formalize these processes through a Memorandum of Understanding with DOH. This MOU will specify that HRLA will supply DHCF with the reports which contain details about deficiencies, and the imposition of any sanctions consistent with District statutory and regulatory authority. The MOU will be executed by March 30, 2016.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of

restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Health Health Regulatory Licensing Agency (DOH HRLA) is responsible for the monitoring of unauthorized use of restraints and/or seclusion on an annual basis, at a minimum.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

DHCF's LTC Administration will conduct an initial provider screening and readiness review to ensure provider qualifications. These include developing policies and procedures around maintaining the person's health, safety, and welfare. Under this policy, DHCF strictly prohibits use of seclusion. The District prohibits the use of unauthorized use of seclusion. The Supervisory RN and Case Manager will monitor the beneficiary in order to detect any unauthorized use of seclusion. If detected, an incident report is completed by the Supervisory RN and/or Case Manager. The incident is reported to Department of Healthcare Finance who in turn, reports to Department of Health for further review and investigation.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. Applicability.** Select one:

No. This Appendix is not applicable (*do not complete the remaining items*)

Yes. This Appendix applies (*complete the remaining items*)

- b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the state:

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

- iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

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Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.** (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

**Percent of beneficiaries' serious reportable incidents reported within 24 hours or next business day of notification. Number of critical incidents reported (denominator).
Number of beneficiaries' serious reportable incidents reported within 24 hours or next business day (numerator).**

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Percent of all beneficiaries' serious reportable incidents with investigations initiated within 48 hours. Number of all critical incidents investigated (denominator). Number of all beneficiaries' serious reportable incidents with investigations initiated within 48 hours (numerator)

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Percent of substantiated serious reportable incidents (abuse, neglect, exploitation, unexplained death only) resulting in development & implementation of prevention strategies. $N = \#$ substantiated serious reportable incidents (abuse, neglect, exploitation, unexplained death only) resulting in development & implementation of prevention strategies. $D = \text{Total \# substantiated serious reportable incidents}$.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percentage of serious reportable incident investigation outcomes notified to the person within 5 business days of closure of investigation. D= Number of serious reportable incident investigations that were completed/closed. N= Number of serious reportable incident investigations where beneficiary and/or representative was notified of outcome within 5 business days of investigation's closure.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">90%</div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Percentage of beneficiaries with complaints investigated with-in 7 days. Total Number of complaints (denominator). Number of beneficiaries with complaints investigated with-in 7 days (numerator)

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence

		Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Percent of beneficiaries' serious reportable incidents where follow-up was

implemented within 30 days of closure of investigation. Number of serious reportable Incident investigations closed/completed (denominator). Number of beneficiaries' serious reportable incidents where appropriate follow-up was implemented within 30 days of closure of investigation (numerator).

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>90%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- d. Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percentage of beneficiaries that received an annual preventive health visit. N=
Number of beneficiaries who received an annual preventive health visit. D= **Number**
of beneficiaries who were due for a preventive health visit.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Other Specify: <div data-bbox="405 389 799 472" style="border: 1px solid black; height: 37px; width: 247px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div data-bbox="868 674 1262 757" style="border: 1px solid black; height: 37px; width: 247px; margin-top: 5px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

DHCF has in place several mechanisms to monitor and analyze EPD waiver performance. The LTCA Oversight and Monitoring Division conducts compliance reviews on performance measures of all waiver assurances. The LTCA Oversight and Monitoring Division is responsible for the discovery and remediation process of individual and systemic issues.

On a monthly basis the Division of Quality and Health Outcomes (DQHO) in concert with the LTCA Oversight and Monitoring Division convenes a Quality Management Committee (QMC). The purpose of QMC is to provide oversight of the EPD program to evaluate the performance and implement quality improvement strategies for continuous quality improvement.

Performance measures are derived from the actual EPD waiver measures approved by CMS or other measures that the program feels are important to monitor. A report card of measures is maintained in the DQHO. The EPD staff submits performance rates to DQHO for tracking and trending. Once performance measure rates are submitted to the DQHO, an analysis is completed on individual performance measures and overall program performance.

The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF.

Additionally, DHCF utilizes a work plan that tracks performance and prioritizes improvement efforts and implementation of the Plan-Do-Check-Act quality improvement process. The work plan will be utilized to formally develop the written quality strategy. This strategy will be in compliance with CMS's national initiatives for home and community based settings. This strategy will be aligned with the National Quality Strategy of better care, healthy people, healthy communities, and affordable care. This program will fit within the Agency's strategic mission and strategic goals.

Task 1. The DQHO partners with the LTCA Monitoring and Oversight Division to conduct a comprehensive program evaluation of the previous EPD waiver program. This evaluation will include an analysis of all components of the EPD waiver. It shall include an iterative process for assessing quality performance, identify opportunities for improvement, and outline recommendations for targeted quality improvement processes and measuring and monitoring of the program's overall effectiveness. This evaluation will be completed by April 2017.

Task 2. The program analysis in addition to the work plan will be used to develop a comprehensive five year quality strategy. The quality strategy will include a process for assessing and revising performance measures at least annually.

Task 3. Provisions will be included to ensure that all applicable providers delivering services to waiver participants shall be subject to quality standards, including but not limited to, guidance issued by the Centers for Medicare and Medicaid Services (CMS) and rules issued by DHCF related to quality improvement activities. All applicable service providers shall be subject to quality standards that adhere to CMS and DHCF guidance related to DHCF's EPD quality strategy, and provide for a continuous Quality Assessment and Performance Improvement (QAPI) program consistent with these requirements.

The quality strategy will be completed and implemented by December 2017.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The DLTC EPD has monitoring staff who conduct a review of the provider from which the complaint originated and subsequently triages complaints to identify and investigate the nature of the complaint and refers it to the appropriate regulatory agency. Specifically, if a complaint occurred within a specific provider agency and that agency did not initiate an internal timely investigation, then DHCfs CLTC monitoring unit would send the provider agency a deficiency report and refer it to the appropriate agency for follow-up, ie. Program Integrity, HRLA, Adult Protective Services, etc.

When DHCF detects problems in Health and Welfare, it has several sequential strategies it will use to address them. These include:

- 1) Meeting with providers (individually or as a group) to deliver education to correct the detected problems. This will most often be used for a first-time occurrence of a problem of a specific type. Meetings will be conducted by staff from DHCfs Elders and Persons with Physical Disabilities Branch. If a problem is detected across multiple providers, DHCF will send an official written transmittal to all providers describing the problem and how DHCF requires it to be addressed. Documentation of these efforts will be made by DHCfs Elders and Persons with Physical Disabilities Branch as notes on individual providers, notes on the agenda of monthly provider meetings, or as copies of the transmittals.
- 2) Problems that recur will be addressed through additional training and the delivery of a written notice from DHCF requiring the correction of the problem. DHCfs EPD is responsible for documenting the remediation process with individual providers and retains documentation.
- 3) Problems that persist will be addressed through more stringent means including the recoupment of Medicaid payments associated with claims related to the service plan problem. Such recoupments are handled by DHCfs Office of Utilization Management which maintains records of all such recoupments.
- 4) Serious and /or repeated violation of standards for service planning can result in termination of the provider in accord with DHCfs Administrative regulations. Provider terminations are handled by DHCfs Office of Program Integrity which maintains documentation of all such provider actions.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

As mentioned under question ii (Methods for Discovery), DHCF has in place several mechanisms to monitor and analyze EPD waiver performance. The LTCA Oversight and Monitoring Division conducts compliance reviews on performance measures of all waiver assurances. The LTCA Oversight and Monitoring Division is responsible for the discovery and remediation process of individual and systemic issues.

The District's DQHO has a Program Analyst dedicated to the LTCA and the EPD waiver. This Program Analyst has assisted in development and implementation of an EPD work plan to ensure that all elements of the waiver are in compliance. The Analyst also chairs a Quality Management Committee meeting on a monthly basis that implements the Quality Strategy outline in Appendix H including a Continuous Quality Improvement plan. This process includes the development of Quality Improvement Projects for any assurance that is performing below 86%.

Specifically related to the timeliness of investigations, the oversight and monitoring team review the reported incidents on a monthly basis to identify individual and provider patterns/trends and to ensure that providers are managing incidents investigations as per DHCF's policy and procedures. The LTCA staff from oversight and monitoring team generate discovery to the providers that are not managing incidents for plan of action and follow up. Additionally, the oversight and reporting team analyze the incident tracking on a quarterly basis and make recommendations to the operations division for systemic improvement on incident management

The District has reviewed with the providers the importance on incident management and its follow up during the monthly provider leadership meetings and this has resulted in the timeliness of investigations measure to increase by twenty-one percentage points from WY5 QTR1 at 27% to WY5 QTR3 at 48%.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The District has a system of Continuous Quality Improvement to ensure that all requirements outlined within the waiver are met. The LTCA and the DQHO works together to develop performance measure indicators ensuring the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The District reviews aspects of the waiver for compliance and when it is found that there is not compliance the District issues a discovery for each individual instance of non-compliance. Each individual discovery is remediated on an individual basis. The District evaluates the system as a whole and anytime that the system is performing at below 86%, it is determined there is a need for a Quality Improvement Project (QIP). The only time a QIP is not implemented is the District believes there is justification and CMS approves this justification. The impact of QIPs will be analyzed to determine efficacy and if they are not found to be effective a new barrier analysis will be conducted and or new interventions developed.

ii. System Improvement Activities

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: 	Other Specify:

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Billing and Claims:

The effectiveness of any system change is measured by assessing whether the changes truly function as designed and whether the design produced the anticipated results. HCOA is responsible for ensuring that changes made to the MMIS are in line with the agreed upon design. Once a change is implemented in production ACS monitors the change and captures three instances where the change worked as designed. A CSR can only be closed once the proof in production requirement has been satisfied.

In order to assess whether the design is producing the anticipated results, reports are often created that allow program staff to monitor progress. Reports can be created on an ad hoc basis or put into production as a standard daily, weekly, monthly, quarterly or annual report. All standard reports are placed in a web based reports repository called Reports On Line (ROL) that is accessible via the secure portion of the DHCF web portal. DHCF employees are provided access to the secure portion of the web portal via user names and passwords.

In addition to canned reports certain DHCF staff members have access to a Cognos database that can be used to access data directly and generate custom reports in real time. HCOA works closely with program staff to ensure that the database contains the data elements needed to perform proper analysis and that data is being interpreted correctly.

The District's DQHO has a Program Analyst dedicated to the LTCA and the EPD waiver. This Program Analyst has assisted in development and implementation of an EPD work plan to ensure that all elements of the waiver are in compliance. The Analyst also chairs a Quality Management Committee meeting on a monthly basis that implements the Quality Strategy including a Continuous Quality Improvement plan.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DHCFs DQHO conducts an evaluation of the waiver program that includes recommendations that is presented at the QMC annually. The DHCF Quality Strategy is updated at this time if appropriate.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Financial integrity is promoted through pre- and-post payment processes. Pre-payment activities are described in section I-2-d Billing Validation Process. Per the enrollment process outlined in Appendix C, Provider Specification, providers are required to secure an independent financial statement audit.

However, the State Agency is required to perform post payment audits under Chapter 42 of Title 29, DC Municipal Regulations (29 DCMR § 4236). To fulfill this requirement, a random sample of claims for selected waiver services is annually audited by the State Agency's Division of Program Integrity - Surveillance and Utilization Branch. The random sample size is determined using the industry standard statistical software package, RAT-STATS. The standard sample period is one year, although there may be deviation based on the size and scope of the provider under review. The District uses attribute sample size determination. In the sampling methodology, the universe is based on claims paid.

These audits compare information submitted on the claims to patient care documentation and assess whether or not the services billed for are: included in the participant's approved service plan, were provided, and meet other requirements of the waiver. In instances in which claims appear to be unsubstantiated, the state agency begins a recoupment process and returns the federal share, when recoupment is upheld through reconsideration and appeals processes, consistent with federal regulations. On-site reviews will be conducted when data analysis, previous interactions with the provider, complaints, or other information provide indications there may be concerns with the timeliness of response by the provider, lack of response, or potential for modification of records. For on-site audits DPI, normally DPI uses a confidence level of 90 and precision range of 15, although based on discussions with DHCF's Office of General Counsel and in accordance with DPI policy, DPI will utilize one of the following combinations dependent on case specifics:

- Confidence Level 95 and Desired Precision Range 10*
- Confidence Level 90 and Desired Precision Range 10*
- Confidence Level 90 and Desired Precision Range 15*
- Confidence Level 90 and Desired Precision Range 20*

For desk audits, DPI uses 100% claims evaluation for known outliers, such as home health services, services exceeding service limits, and concurrent delivery of services, for a specific time-period (normally fiscal or calendar year). Several types of services are specifically prohibited in District/Federal regulations across multiple or individual service categories. In the District's Division of Program Integrity, audits are generally conducted by SURS or the Surveillance and Utilization Branch and investigations by the Investigations Branch. Division of Program Integrity management monitors the activities of the branches to ensure there is no duplication of efforts, in addition bi-weekly meetings are held to complete collaboration on activities and to coordinate efforts as needed.

SURS audits and LTCA's EPD Waiver Oversight and Monitoring reviews use the same sampling methodology, although the areas of focus are different. There are approximately 40 providers in the waiver program. All providers are subject to post-payment review, although DHCF focuses on claims evaluation for known outliers.

Random sampling of such claims is an efficient approach to validation and ensuring appropriate payment recovery because the rate of denied claims in the sample can be applied to the universe of similar claims from the provider and a percent of payment equal to the error rate observed in the sample can be recovered. Also, providers identified as receiving an overpayment are required to provide a plan of correction which is included in all proposed notice of overpayment letters. A spreadsheet is maintained to track audits, including the submission of plans of correction. Additional notification is provided to non-complaint providers. As part of the normal Surveillance and Utilization Review process, past behavior of selected providers are reviewed including submission and compliance with plans of correction.

In addition, the District of Columbia Office of the Inspector General conducts audits, as indicated.

Finally, every year, the entire Medicaid grant, including the portions funding the EPD Waiver, is audited as part of the Single Audit of all the federal grants awarded to the District. The Office of Integrity and Oversight within the Office of the Chief Financial Officer (of the District) oversees the Single Audit. In FY2015 the single audit was conducted by BDO USA, LLP.

The DHCF's Division of Program Integrity shall perform ongoing audits and post-payment reviews. DHCF's Long Term Care Administration's EPD Waiver Monitoring/Oversight team shall also conduct ongoing reviews of providers to ensure adherence with various programmatic standards. Both processes are outlined below in accordance with the EPD Waiver's proposed regulations.

Please see Appendix E(i)(iv) for a description of the post-payment review processes specific to the VF/EA FMS-Support Broker entity for the Services My Way program.

The satisfaction survey is conducted sixty (60) days after a participant's enrollment into the Services My Way program. The survey is comprised of seven (7) questions related to the VF/EA FMS-Support Broker entity enrollment process and ongoing services. If a participant/representative employer indicates an area of dissatisfaction on the survey, DHCF contacts the VF/EA FMS-Support Broker entity to communicate the issue and request additional information depending on the type of complaint. If the complaint is directly related to the VF/EA FMS-Support Broker entity's customer service, the issue is resolved by the contract administrator, who is responsible for ensuring the VF/EA FMS-Support Broker entity's compliance with all terms of its contract. If the survey results indicate that the VF/EA FMS-Support Broker entity is not meeting the service delivery standards set forth in the contract, DHCF will require the entity to remediate the issue(s) and the entity may be found in breach of its contract with DHCF.

AUDITS AND MONITORING/OVERSIGHT REVIEWS

The DHCF's Division of Program Integrity shall perform ongoing audits to ensure that the provider's services for which Medicaid payments are made are consistent with programmatic duties, documentation, and reimbursement requirements as required under Chapter 42 of Title 29 of the DCMR.

The audit process shall be routinely conducted by DHCF to determine, by statistically valid scientific sampling, the appropriateness of services rendered to EPD Waiver program beneficiaries and billed to Medicaid.

Each EPD Waiver provider shall allow access, during an on-site audit or review (announced or unannounced) by DHCF, other District of Columbia government officials, and representatives of the United States Department of Health and Human Services, to relevant records and program documentation.

The failure of a provider to timely release or to grant access to program documents and records to the DHCF auditors, after reasonable notice by DHCF to the provider to produce the same, shall constitute grounds to terminate the Medicaid Provider Agreement.

If DHCF denies a claim during an audit, DHCF shall recoup, by the most expeditious means available, those monies erroneously paid to the provider for denied claims, following notice and the period of Administrative Review set forth in accordance with EPD regulations.

The recoupment amounts for denied claims during audits shall be determined by the following formula:

(a) The number of denied paid claims resulting from the audited sample shall be divided by the total number of paid claims from the audited sample; and

(b) The amount derived from (a) shall be multiplied by the total dollars paid by DHCF to the provider during the audit period to determine the amount to be recouped. For example, if a provider received Medicaid reimbursement of ten thousand dollars (\$10,000) during the audit period, and during a review of the claims from the audited sample, it was determined that ten (10) claims out of one hundred (100) claims are denied, then ten percent (10%) of the amount reimbursed by Medicaid during the audit period, or one thousand dollars (\$1000), would be recouped.

DHCF shall issue a Notice of Proposed Recovery for Medicaid Overpayment (NPRMO) which sets forth the reasons for the recoupment, including the specific reference to the particular sections of the statute, rules, or Provider agreement, the amount to be recouped, and the procedures for requesting an administrative review.

The timelines for responding to the NPRMO and the provider's appeal rights are governed under Chapter 42 of Title 29 of the DCMR.

In addition to audits, the DHCF's Long Term Care Administration's EPD Waiver Oversight and Monitoring team shall conduct two types of reviews:

(a) Annual oversight and monitoring reviews to ensure compliance with established federal and District regulations and applicable laws governing the operations and administration of the EPD Waiver Program; and

(b) Quarterly compliance reviews to ensure adherence with the EPD Waiver Program's performance measures.

Each waiver services provider shall allow the EPD Waiver oversight and monitoring team access, during an on-site

oversight/monitoring process (announced or unannounced).

As part of the oversight and monitoring process, providers shall grant access to any of the following documents, which may include but shall not be limited to the following:

- (a) Person-Centered Plan (PCP) and Plan of Care/ service delivery plan;
- (b) Employee records;
- (c) A signed, and current copy of the Medicaid Provider Agreement;
- (d) Licensure information;
- (e) Policies and Procedures;
- (f) Incident Reports and Investigation Reports; and
- (g) Complaint related reports.

DHCF's EPD Waiver Oversight and Monitoring Team shall issue a Statement of Findings and Opportunities for Improvement Plan ("improvement plan") within fifteen (15) calendar days of the annual oversight and monitoring exit meeting. Providers shall submit a plan of correction within fifteen (15) calendar days of the date of receipt of DHCF's improvement plan

DHCF's EPD Waiver Oversight and Monitoring team shall generate a performance measures discovery/remediation report ("remediation report") within five (5) business days of completion of the quarterly performance measures-related review. Providers shall submit a performance measures-related remediation plan ("remediation plan") within ten (10) business days of receipt of the report.

The failure to provide an acceptable plan of correction, remediation plan or adherence to the improvement plan or remediation report, may result in a prohibition of new admissions, referral to the DHCF's Division of Program Integrity for further investigation or imposition of a sanction or termination of the Medicaid Provider Agreement.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percentage of claims reviewed by program integrity audits that failed standards.

Percentage of claims reviewed by program integrity for audits (denominator). Number of waiver service claims reviewed by program integrity audits that met standards (numerator).

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Confidence Interval of no less than 90% with an error rate of no greater than 20 </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify:

		dependent on case specifics one of the following: Confidence Level 95/Error rate 10 Confidence Level 90/Error rate 10 Confidence Level 90/Error rate 15 Confidence Level 90/Error rate 20
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percentage of waiver claims reviewed that were paid using the correct rate as specified in the waiver application. Number of waiver claims reviewed that were paid using the correct rate as specified in the waiver application/ D= Number of waiver claims reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> Confidence Interval of no less than 90% and an error rate no greater than 20 </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify:

		<i>dedependent on case specifics one of the following:</i> <i>Confidence Level 95/Error rate 10</i> <i>Confidence Level 90/Error rate 10</i> <i>Confidence Level 90/Error rate 15</i> <i>Confidence Level 90/Error rate 20</i>
	<i>Other Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

In addition, scheduled reporting to CMS using 372 cost neutrality formulas provides opportunities for review, analysis, detection, and refinement.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

DHCF has in place several mechanisms to monitor and analyze EPD waiver performance. The LTCA Oversight and Monitoring Division conducts compliance reviews on performance measures of all waiver assurances. The LTCA Oversight and Monitoring Division is responsible for the discovery and remediation process of individual and systemic issues.

On a monthly basis the Division of Quality and Health Outcomes (DQHO) in concert with the LTCA Oversight and Monitoring Division convenes a Quality Management Committee (QMC). The purpose of QMC is to provide oversight of the EPD program to evaluate the performance and implement quality improvement strategies for continuous quality improvement.

Performance measures are derived from the actual EPD waiver measures approved by CMS or other measures that the program feels are important to monitor. A report card of measures is maintained in the DQHO. The EPD staff submits performance rates to DQHO for tracking and trending. Once performance measure rates are submitted to the DQHO, an analysis is completed on individual performance measures and overall program performance.

The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF.

Additionally, DHCF utilizes a work plan that tracks performance and prioritizes improvement efforts and implementation of the Plan-Do-Check-Act quality improvement process. The work plan will be utilized to formally develop the written quality strategy. This strategy will be in compliance with CMS's national initiatives for home and community based settings. This strategy will be aligned with the National Quality Strategy of better care, healthy people, healthy communities, and affordable care. This program will fit within the Agency's strategic mission and strategic goals.

Task 1. The DQHO partners with the LTCA Monitoring and Oversight Division to conduct a comprehensive program evaluation of the previous EPD waiver program. This evaluation will include an analysis of all components of the EPD waiver. It shall include an iterative process for assessing quality performance, identify opportunities for improvement, and outline recommendations for targeted quality improvement processes and measuring and monitoring of the program's overall effectiveness. This evaluation will be completed by April 2017.

Task 2. The program analysis in addition to the work plan will be used to develop a comprehensive five year quality strategy. The quality strategy will include a process for assessing and revising performance measures at least annually.

Task 3. Provisions will be included to ensure that all applicable providers delivering services to waiver participants shall be subject to quality standards, including but not limited to, guidance issued by the Centers for Medicare and Medicaid Services (CMS) and rules issued by DHCF related to quality improvement activities. All applicable service providers shall be subject to quality standards that adhere to CMS and DHCF guidance related to DHCF's EPD quality strategy, and provide for a continuous Quality Assessment and Performance Improvement (QAPI) program consistent with these requirements.

The quality strategy will be completed and implemented by December 2017.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

As mentioned above under question ii (Methods for Discovery), DHCF has in place several mechanisms to monitor and analyze EPD waiver performance. The LTCA Oversight and Monitoring Division conducts compliance reviews on performance measures of all waiver assurances. The LTCA Oversight and Monitoring Division is responsible for the discovery and remediation process of individual and systemic issues.

On a monthly basis the Division of Quality and Health Outcomes (DQHO) in concert with the LTCA Oversight and Monitoring Division convenes a Quality Management Committee (QMC). The purpose of QMC is to provide oversight of the EPD program to evaluate the performance and implement quality improvement strategies for continuous quality improvement.

Performance measures are derived from the actual EPD waiver measures approved by CMS or other measures that the program feels are important to monitor. A report card of measures is maintained in the DQHO. The EPD staff submits performance rates to DQHO for tracking and trending. Once performance measure rates are submitted to the DQHO, an analysis is completed on individual performance measures and overall program performance. The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF.

Additionally, DHCF utilizes a work plan that tracks performance and prioritizes improvement efforts and implementation of the Plan-Do-Check-Act quality improvement process. The work plan will be utilized to formally develop the written quality strategy. This strategy will be in compliance with CMS's national initiatives for home and community based settings. This strategy will be aligned with the National Quality Strategy of better care, healthy people, healthy communities, and affordable care. This program will fit within the Agency's strategic mission and strategic goals.

Task 1. The DQHO partners with the LTCA Monitoring and Oversight Division to conduct a comprehensive program evaluation of the previous EPD waiver program. This evaluation will include an analysis of all components of the EPD waiver. It shall include an iterative process for assessing quality performance, identify opportunities for improvement, and outline recommendations for targeted quality improvement processes and measuring and monitoring of the program's overall effectiveness. This evaluation will be completed by April 2017.

Task 2. The program analysis in addition to the work plan will be used to develop a comprehensive five year quality strategy. The quality strategy will include a process for assessing and revising performance measures at least annually.

Task 3. Provisions will be included to ensure that all applicable providers delivering services to waiver participants shall be subject to quality standards, including but not limited to, guidance issued by the Centers for Medicare and Medicaid Services (CMS) and rules issued by DHCF related to quality improvement activities. All applicable service providers shall be subject to quality standards that adhere to CMS and DHCF guidance related to DHCF's EPD quality strategy, and provide for a continuous Quality Assessment and Performance Improvement (QAPI) program consistent with these requirements.

The quality strategy will be completed and implemented by December 2017.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Provider payment rates are uniform for every provider. DHCF elicits public comments through District rule-making process, and information regarding payment rates are available to waiver participants via publication of proposed and ratified rules. Office of Rates, Reimbursement and Financial Analysis (ORRFA) is responsible for rate development with assistance from LTCA/EPD Branch. Rate information is available to Medicaid participants and community members upon request and on DHCF website at <http://dhcf.dc.gov>. Meetings are held with providers, community stakeholders, to assess outstanding waiver issues, and discuss rates and rate structure for direct care workers (PCA) and review assessment of expertise and capacity of providers and services.

Rate structures are determined based on geographic market analysis in surrounding jurisdictions. There is no automatic inflation increase. In 2006 direct care worker rates were adjusted to provide a realistic rate in line with neighboring jurisdictions and consistent with DC Council mandate to provide a rate acceptable for direct care workers (a living wage rate).

The rate-setting methodology used for Medicaid services delivered through traditional agency-based model will remain the same for services that are participant-directed. Participants who elect to use PDS will determine hourly rate paid to their participant-directed workers within range set by DHCF, which falls between District's established living wage and the rate paid to PCAs delivering Waiver services through the agency-based model. The Vendor Fiscal/Employer Agent Financial Management Services (VF/EA FMS) - Support Broker entity will assist participants who elect to use PDS through provision of financial management and support broker services, and will receive a PMPM payment for provision of these services. In addition to the PMPM payment, VF/EA FMS-Support Broker entity will receive one-time payment for enrolling participant/representative employer into its employer database and a one-time payment for enrolling each participant-directed worker into its payroll system. Rates for all three (3) types of payment made to VF/EA FMS-Support Broker entity are set through contract negotiation process on annual basis and included in VF/EA FMS-Support Broker entity's contract with DHCF.

The reimbursement methodology and rate for Assisted Living services has been updated to reflect reasonable cost of providing service in the District. The daily rate is predicated by the following factors:

- (1) A PCA wage, based on the District Living Wage rate of \$13.84 per hour, plus overtime and time off calculations.*
- (2) The rate includes a number of hours for LPN staffing plus overtime and time off calculations to address Medication Administration rules of the District.*
- (3) The rate includes compensation for RN oversight for medication administration and health assessments per District policy of 1:12 HCBS individuals.*
- (4) The rate includes compensation for House Manager for (PCA) supervision per District policy of 1:12 HCBS waiver individuals.*
- (5) Each employee wage above has a 20% fringe benefit rate applied to reflect actual costs in the District.*
- (6) A general and administrative percentage of 13% is applied based on the total costs of all services. This percentage is based on reasonable comparison with other comparable residential care provider categories.*
- (7) Lastly a 93% occupancy rate is applied to the rate to account for hospitalization, LTC, and vacation time that is not billable to HCBS waiver program. The 93% factor was used, to promote parity with other residential services that have a vacancy factor.*

Based on the computation of these factors, the daily reimbursement rate for Assisted Living services shall be one hundred and fifty five dollars (\$155). The rate will be inflated annually, starting in FY 2016, by adjustment to the Living Wage and inflation based on Centers for Medicare and Medical Services (CMS) Skilled Nursing Facility Market Basket Index.

Medicaid reimbursement for Community Transition services shall be limited to a maximum of five thousand dollars (\$5,000) per person for the duration of the EPD Waiver period as a one-time, non-recurring expense.

The reimbursement methodology and rates for case-management services under the EPD Waiver is designed as an all-inclusive monthly (PMPM) capitation rate. The capitation rate provides better correlation between reimbursements and the number of beneficiaries receiving case management services. The methodology used for establishing capitation rate includes: An average industry salary for case managers. In determining the salary, DHCF relied on current compensation scale of case managers providing similar case management services at the District's Department of Disability Services (DDS). All case managers at DDS are called "Service Coordinators" with job functions generally classified grade 11. While compensation amounts "fully loaded" for grade 11-1 and 11-10, including salary and benefits is \$73,489.22 and \$94,748.61. The caseload assigned to case manager at DDS crosses a large span of cases, and is captured numerically on a client's-to-case manager ratio. The ratio ranges from 45:1 for DDS waiver population, or

20:1 for more intense cases. However, for purposes of EPD waiver population, an estimated caseload of 30:1 will be used. This estimated ratio is preferable for EPD waiver population given the intensity of service required. HHs providing case management to EPD beneficiaries will ONLY be able to bill for HH case management (and will NOT be able to bill for EPD case management services).

Reimbursement for Chore Aide and Homemaker Services under the EPD Waiver Home care services are usually provided by Home Health Agencies, but may also be obtained from independent providers. Personnel are assigned according to needs and wishes of each client. Prior authorization (PA) is required to provide services. DHCF reimbursed Home Health Agency for Chore Aide and Homemaker services under the EPD Waiver. Chore Aides are currently reimbursed an hourly rate of \$15.00 and Homemaker at \$10.48. The current living wage in the District is \$13.80 hourly, and at minimum chore aide and homemaker professionals must be reimbursed at this wage. To attract providers and provide access to services for beneficiaries, DHCF is increasing reimbursement rates for Chore Aide and Homemaker services to reimburse providers at rates that cover necessary employment related taxes, benefits and other administrative overhead costs. The established reimbursement methodology is as follows: The reimbursement rate is calculated using the living wage of \$13.80 as the base, an addition of 30% for employee related taxes, benefits and overhead costs. The rate will be inflated annually beginning with FY 2016, by adjustment to the living wage and inflation based on the Centers for Medicare and Medical Services (CMS) Skilled Nursing Facility Market Basket Index.

Computation-1) Base Rate (Living Wage) = \$13.80 + \$4.14 (30%) 2) FY 2016 Rate – October 1, 2015 \$17.94 x 2.3% (CPI) = \$18.35

EPD waiver ADHP providers shall be reimbursed at the current reimbursement rate for Acuity Level 2, ADHP under the current 1915(i) State Plan reimbursement methodology and rate. The daily rate for a program serving participants with a maximum acuity level with at least one staff member shall be one hundred and twenty five dollars and seventy eight cents (\$125.78) per day.

Effective October 1, 2015 (FY 2016) and thereafter, the uniform per-diem rates, shall be inflated by the Centers for Medicare and Medical Services (CMS) Skilled Nursing Facility Market Basket Index.

DHCF updated reimbursement rates for PCA services based on audit of Home Health Agency (HHA) cost reports. The new rate covers the DC Living Wage increases, employment related taxes, employee benefits and reasonable administrative overhead costs. The rate will be inflated annually, starting in FY 2016, based on adjustments to the Living Wage or the inflation based on the Centers for Medicare and Medical Services (CMS) Skilled Nursing Facility Market Basket Index. The reimbursement methodology was established based on the following components:

- (1) District's living wage of \$13.80 as established by the DC Department of Employment Services;
- (2) 10.83% Taxes – Social Security (6.2%), Medicare (1.45%), Workers Compensation (2%) and Unemployment Benefits (1.18%);
- (3) 7.4% Employee Benefits – Medical Insurance and Sick Leave Provision; and
- (4) 18% - Provider Indirect Administrative Overhead based on reasonable comparisons with other comparable provider categories.

The District has established four rates for four different environmental accessibility adaptations with a maximum allowable lifetime cost per recipient of \$10,000. These rates were based upon a geographic market analysis of costs and a review of contractors across the District of Columbia, Maryland and Virginia. Major environmental accessibility adaptations require the assessment of rehabilitation engineer or other professional qualified to make a home accessibility assessment. This assessment includes evaluation of the current home and identifies the most cost-effective and beneficial manner to permit accessibility of the for the waiver recipient. Once the most cost-effective and beneficial accessibility adaptation is identified, and specifications have been developed, bids are obtained to secure the most competitive price. DHCF provides payment based upon the lowest of the submitted price quotes. This reimbursement methodology has been in effect as part of the District's approved waiver since 2007. The four rates are:

- (a) Unit A: Stair Climber - \$2,000
- (b) Unit B: Porch Lift - \$3,000
- (c) Unit C: Bathroom Modifications - \$2,000; and
- (d) Unit D: Small Ramp - \$90.00 per linear foot.

Respite care is short-term care provided to individual only when necessary to relieve family members or other persons caring for the individual at home. The reimbursement methodology for (1-17 hours) respite mirrors that of PCA services. The reimbursement methodology was established based on the following components:

- (1) District's living wage of \$13.80 as established by the DC Department of Employment Services;

(2) 10.83% Taxes – Social Security (6.2%), Medicare (1.45%), Workers Compensation (2%) and Unemployment Benefits (1.18%);

(3) 7.4% Employee Benefits – Medical Insurance and Sick Leave Provision; and

(4) 18% - Provider Indirect Administrative Overhead based on reasonable comparisons with other comparable provider categories.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All fee for service claims including those for waiver services are submitted to the Fiscal Intermediary, currently ACS Government Healthcare Solutions, for processing in the MMIS. Claims can be submitted on paper or electronically via HIPAA compliant transactions. Providers can submit electronic claims via the DHCF web portal, using billing agents or directly through third party software.

Once submitted, claims are processed through the MMIS and run through a large set of edits to ensure proper format and compliance with Federal and District regulations. Edits ensure that beneficiary's are eligible to receive the services rendered, providers are eligible to provide those services and that services were rendered appropriately. Claims that fail an edit can either deny or suspend for further review. Suspended claims are reviewed by ACS claims staff and are set to either pay or deny based on District rules and regulations.

Remittance Advices (RA) are produced and distributed to providers after every payment cycle identifying all claims processed their disposition (Paid/Denied/Suspended) and the total amount due to them. Any claims that do not pay are accompanied with a description of the edit that caused them to either deny or suspend. Those descriptions are used by providers to correct errors and resubmit claims for payment.

The MMIS adjudicates claims on a daily basis and runs payment cycles once a week. Payment cycles result in warrant files that are submitted to the District Treasury. All checks are generated and issued by the Treasury. The Treasury returns a file to the MMIS once checks are issued that identify check numbers and dates. The MMIS updates the payment file to include this information and maintains it as part of the permanent record.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Billing validation consists of both pre- and-post payment processes. Pre-payment validation consists of edits within the MMIS claims processing logic to ensure that three conditions exist prior to paying a waiver claim. The first condition is that the beneficiary must be enrolled in the waiver on the date of service. The system verifies this by checking the beneficiary's program code for the date of service and ensuring the code is associated with the waiver. The second condition is that the provider is eligible to render waiver services to waiver beneficiaries. Providers must obtain waiver provider numbers in order to render waiver services to beneficiaries. The system checks the billing provider number and validates that it is a waiver provider type. The final prepayment validation edits verify that the services were provided in accord with limits and requirements specified in the waiver; such as that prior authorization was given for each waiver service delivered, and that the quantity of waiver services provided does not exceed limits specified in the waiver. If any of these conditions is false, the claim will be denied for payment.

Post payment validation of claims is conducted by the State Agency's Division of Program Integrity - Surveillance and Utilization Branch. Staff from this Branch annually audit claims submitted for waiver services. These audits consist of pulling a random sample of claims and then going on-site to waiver providers' offices to compare information submitted on the claims to patient care documentation. These audits always assess whether or not the service is included in the participant's approved service plan and whether evidence exists that services were provided. In instances in which documentation does not affirm either of these, the state agency recovers the payment made and returns the federal share. Random sampling of such claims is an efficient approach to validation and ensuring appropriate payment recovery because State regulations provide the state agency with the authority to extrapolate the rate of denied claims in the sample to the universe of similar claims from the provider and recover a percent of payment equal to the error rate observed in the sample.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):**

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures

on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not

voluntarily agree to contract with a designated OHCDs; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDs arrangement is employed, including the selection of providers not affiliated with the OHCDs; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDs meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDs contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDs arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

Not Applicable. *There are no local government level sources of funds utilized as the non-federal share.*

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

The reimbursement methodology and rate for Assisted Living services has been updated to better reflect the reasonable cost of providing the service in the District.

The daily rate is predicated by the following factors:

8) A Personal Care Aide (PCA) wage, which is based on the District Living Wage rate of \$13.84 per hour, plus overtime and time off calculations.

9) The rate includes a number of hours for Licensed Practical Nurse (LPN) staffing plus overtime and time off calculations to address the Medication Administration rules of the District.

10) The rate includes the compensation for RN oversight for medication administration and health assessments per District policy of 1:12 HCBS individuals.

11) The rate includes the compensation for House Manager for (PCA) supervision per District policy of 1:12 HCBS waiver individuals.

12) Each employee wage above has a 20% fringe benefit rate applied so as to reflect actual costs in the District.

13) A general and administrative percentage of 13% is applied based on the total costs of all services. This percentage is based on a reasonable comparison with other comparable residential care provider categories.

14) Lastly a 93% occupancy rate is applied to the rate to account for hospitalization, LTC, and vacation time that is not billable to the HCBS waiver program. The 93% factor was used, so as to promote parity with all other residential services which also have a vacancy factor.

Based on the computation of these factors, the daily reimbursement rate for Assisted Living services shall be \$155.

The rate will be inflated annually beginning with FY 2016, by any adjustment to the Living Wage or the inflation based on the Centers for Medicare and Medical Services (CMS) Skilled Nursing Facility Market Basket Index.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**a. Co-Payment Requirements.****iv. Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)****b. Other State Requirement for Cost Sharing.** Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	14189.30	58650.42	72839.72	70070.93	9998.35	80069.28	7229.56
2	15024.91	62177.83	77202.74	72185.00	10268.38	82453.38	5250.64
3	15516.76	64250.51	79767.27	74299.07	10538.41	84837.48	5070.21
4	17841.47	65602.75	83444.22	76413.14	10808.44	87221.58	3777.36
5	18501.52	68037.84	86539.36	78527.21	11078.47	89605.68	3066.32

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (1 of 9)****a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	5160		5160
Year 2	5260		5260
Year 3	5360		5360
Year 4	5460		5460
Year 5	5560		5560

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (2 of 9)**

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay was determined by taking the total unduplicated participants divided by the total days of waiver coverage for each prior waiver year. All the past history was then used to project the remaining waiver years using a trend analysis. In completing the trend, the days were restricted not to exceed 365 days in a year. The District is continuing to trend the historic average lengths of stay, but we have revised the historic period on which we have based the trend. The District is now basing the trend on actual average lengths of stay from the second year of the previous waiver (January 4, 2008 – January 3, 2009) through the most recent year for which we have data (January 4, 2015 – January 3, 2016). The forecasted average lengths of stay are shown in the table below.

Year	ALOS
Waiver Year 1	309
Waiver Year 2	317
Waiver Year 3	325
Waiver Year 4	333
Waiver Year 5	341

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (3 of 9)**

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D calculates the annual average per person cost for waiver-specific services for individuals in the EPD waiver program. To project this factor for the current waiver period year 5 and the future waiver period years 1-5, we forecasted both the number of users and the utilization level for each waiver-specific service based on historical trends, while also accounting for any anticipated utilization increases/decreases. We then multiplied these two projections together to get annual anticipated total units. Multiplying this figure by the average cost per unit for each service area led to the total cost, by year, by service area. This summation of the total cost, by year, for all service areas divided by total projected unduplicated participants in the waiver program resulted in the forecasted Factor D for the current waiver period year 5 and future waiver period years 1-5.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' for the most recent waiver year (1/4/2015 – 1/3/2016) does not have the provider fraud or changes in claiming that affect older years, so we have used that value as the base. Using that base, we inflated Factor D' at the same rate as the projected growth in Factor D.

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is projected for the current waiver period year 5 and future waiver period years 1-5, by forecasting each year by trending off the historical data.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is projected for the current waiver period year 5 and future waiver period years 1-5, by forecasting each year by trending off the historical data.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Adult Day Health	
Case Management	
Homemaker	
Respite	
Assisted Living	
Chore Aide	
Community Transition Services	
Environment Accessibility and Adaptation Services	
Individual Directed Goods and Services	
Participant-Directed Community Support Services	
Personal Care Aide	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)



d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						4864719.40
Adult Day Health	daily	193	193.00	130.60	4864719.40	
Case Management Total:						13178124.00
Case management per member per month	month	5160	10.00	255.39	13178124.00	
Homemaker Total:						4045710.24
Homemaker	hourly	999	208.00	19.47	4045710.24	
Respite Total:						1177999.76
Respite 1-17 hours/day	1 hour	112	458.00	20.56	1054645.76	
Respite 18-24 hours/day	day	18	22.00	311.50	123354.00	
Assisted Living Total:						1812886.20
Assisted Living	day	62	265.00	110.34	1812886.20	
Chore Aide Total:						13706.88
Chore Aide	hourly	22	32.00	19.47	13706.88	
Community Transition Services Total:						65000.00
Community Transition Services	1 unit	13	1.00	5000.00	65000.00	
Environment Accessibility and Adaptation Services Total:						100000.00
Environment Accessibility and Adaptation Services	1 unit	10	1.00	10000.00	100000.00	
Individual Directed Goods and Services Total:						9216.00
Individual Directed Goods and Services	Item	90	1.00	102.40	9216.00	
Participant-Directed Community Support Services Total:						1253337.30
Participant- Directed Community Support Services	annual	90	1.00	13925.97	1253337.30	
Personal Care Aide Total:						46696082.74
Personal Care Aide					46696082.74	
GRAND TOTAL:						73216782.52
Total Estimated Unduplicated Participants:						5160
Factor D (Divide total by number of participants):						14189.30
Average Length of Stay on the Waiver:						309

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 minutes	3329	2729.00	5.14		
GRAND TOTAL:						73216782.52
Total Estimated Unduplicated Participants:						5160
Factor D (Divide total by number of participants):						14189.30
Average Length of Stay on the Waiver:						309

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						5482744.00
Adult Day Health	daily	212	193.00	134.00	5482744.00	
Case Management Total:						15161055.80
Case management per member per month	month	5260	11.00	262.03	15161055.80	
Homemaker Total:						4191143.84
Homemaker	hourly	1009	208.00	19.97	4191143.84	
Respite Total:						1251961.00
Respite 1-17 hours/day	1 hour	115	458.00	21.10	1111337.00	
Respite 18-24 hours/day	day	20	22.00	319.60	140624.00	
Assisted Living Total:						2906180.64
Assisted Living	day	66	276.00	159.54	2906180.64	
Chore Aide Total:						14058.88
Chore Aide	hourly	22	32.00	19.97	14058.88	
Community Transition Services Total:						250000.00
Community Transition Services					250000.00	
GRAND TOTAL:						79031033.44
Total Estimated Unduplicated Participants:						5260
Factor D (Divide total by number of participants):						15024.91
Average Length of Stay on the Waiver:						317

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	1 unit	50	1.00	5000.00		
Environment Accessibility and Adaptation Services Total:						150000.00
Environment Accessibility and Adaptation Services	1 unit	15	1.00	10000.00	150000.00	
Individual Directed Goods and Services Total:						11556.60
Individual Directed Goods and Services	Item	110	1.00	105.06	11556.60	
Participant-Directed Community Support Services Total:						1561821.80
Participant- Directed Community Support Services	Annual	110	1.00	14198.38	1561821.80	
Personal Care Aide Total:						48050510.88
Personal Care Aide	15 minutes	3362	2712.00	5.27	48050510.88	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						79031033.44 5260 15024.91 317

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						6176492.15
Adult Day Health	daily	233	193.00	137.35	6176492.15	
Case Management Total:						15835476.80
Case management per member per month	month	5360	11.00	268.58	15835476.80	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						83169852.53 5360 15516.76 325

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker Total:						4338657.44
Homemaker	hourly	1019	208.00	20.47	4338657.44	
Respite Total:						1326984.84
Respite 1-17 hours/day	1 hour	118	458.00	21.62	1168431.28	
Respite 18-24 hours/day	day	22	22.00	327.59	158553.56	
Assisted Living Total:						3601257.66
Assisted Living	day	77	286.00	163.53	3601257.66	
Chore Aide Total:						14410.88
Chore Aide	hourly	22	32.00	20.47	14410.88	
Community Transition Services Total:						250000.00
Community Transition Services	1 unit	50	1.00	5000.00	250000.00	
Environment Accessibility and Adaptation Services Total:						200000.00
Environment Accessibility and Adaptation Services	1 unit	20	1.00	10000.00	200000.00	
Individual Directed Goods and Services Total:						13999.70
Individual Directed Goods and Services	Item	130	1.00	107.69	13999.70	
Participant-Directed Community Support Services Total:						1880690.50
Participant- Directed Community Support Services	annual	130	1.00	14466.85	1880690.50	
Personal Care Aide Total:						49531882.56
Personal Care Aide	15 minutes	3396	2696.00	5.41	49531882.56	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						83169852.53 5360 15516.76 325

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg.

Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						6330735.82
Adult Day Health	daily	233	193.00	140.78	6330735.82	
Case Management Total:						16533917.40
Case management per member per month	month	5460	11.00	275.29	16533917.40	
Homemaker Total:						4492531.68
Homemaker	hourly	1029	208.00	20.99	4492531.68	
Respite Total:						1228062.88
Respite 1-17 hours/day	1 hour	121	458.00	22.16	1228062.88	
Respite 18-24 hours/day	day	0	0.00	335.78	0.00	
Assisted Living Total:						4032434.34
Assisted Living	day	81	297.00	167.62	4032434.34	
Chore Aide Total:						14776.96
Chore Aide	hourly	22	32.00	20.99	14776.96	
Community Transition Services Total:						250000.00
Community Transition Services	1 unit	50	1.00	5000.00	250000.00	
Environment Accessibility and Adaptation Services Total:						250000.00
Environment Accessibility and Adaptation Services	1 unit	25	1.00	10000.00	250000.00	
Individual Directed Goods and Services Total:						99452.38
Individual Directed Goods and Services	Item	901	1.00	110.38	99452.38	
Participant-Directed Community Support Services Total:						13275622.32
Participant-					13275622.32	
GRAND TOTAL:						97414427.58
Total Estimated Unduplicated Participants:						5460
Factor D (Divide total by number of participants):						17841.47
Average Length of Stay on the Waiver:						333

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Directed Community Support Services	Annual	901	1.00	14734.32		
Personal Care Aide Total:						50906893.80
Personal Care Aide	15 minutes	3430	2679.00	5.54	50906893.80	
GRAND TOTAL:						97414427.58
Total Estimated Unduplicated Participants:						5460
Factor D (Divide total by number of participants):						17841.47
Average Length of Stay on the Waiver:						333

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						7853671.80
Adult Day Health	daily	282	193.00	144.30	7853671.80	
Case Management Total:						17258128.80
Case management per member per month	month	5560	11.00	282.18	17258128.80	
Homemaker Total:						4648569.12
Homemaker	hourly	1039	208.00	21.51	4648569.12	
Respite Total:						1290314.24
Respite 1-17 hours/day	1 hour	124	458.00	22.72	1290314.24	
Respite 18-24 hours/day	day	0	0.00	344.17	0.00	
Assisted Living Total:						4497985.80
Assisted Living	day	85	308.00	171.81	4497985.80	
Chore Aide Total:						15143.04
GRAND TOTAL:						102868463.30
Total Estimated Unduplicated Participants:						5560
Factor D (Divide total by number of participants):						18501.52
Average Length of Stay on the Waiver:						341

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Chore Aide	hourly	22	32.00	21.51	15143.04	
Community Transition Services Total:						250000.00
Community Transition Services	1 unit	50	1.00	5000.00	250000.00	
Environment Accessibility and Adaptation Services Total:						300000.00
Environment Accessibility and Adaptation Services	1 unit	30	1.00	10000.00	300000.00	
Individual Directed Goods and Services Total:						107596.14
Individual Directed Goods and Services	Item	951	1.00	113.14	107596.14	
Participant-Directed Community Support Services Total:						14270820.12
Participant- Directed Community Support Services	Annual	951	1.00	15006.12	14270820.12	
Personal Care Aide Total:						52376234.24
Personal Care Aide	15 minutes	3464	2662.00	5.68	52376234.24	
GRAND TOTAL:						102868463.30
Total Estimated Unduplicated Participants:						5560
Factor D (Divide total by number of participants):						18501.52
Average Length of Stay on the Waiver:						341