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 waiver's 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 Renewal 01/04/2012

C. Waiver Number:DC.0334
Original Base Waiver Number: DC.0334.

D. Amendment Number:DC.0334.R03.01

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

10/20/15

Approved Effective Date: 10/20/15
Approved Effective Date of Waiver being Amended: 01/04/12

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The Waiver Amendment adds new services, amends existing service descriptions and reimbursement methodologies, adds new provider types and qualification standards and includes requirements to conform with the new Home and Community-Based Services (HCBS) requirements under 42 CFR 441.301 of the federal rulemakings by proposing new conflict-free requirements for case management and person-centered planning to comply with these regulations. It also includes a CMS required HCBS settings Transition Plan to explain how the District's assisted living facilities enrolled under the Waiver will comply with the setting requirements under 42 CFR 441.301.

The Amendment also establishes a new service delivery method or pathway by designating a new government entity for EPD Waiver application assistance, provider referral, and options counseling, and a new Long Term Care Services and Supports (LTCSS) contractor to administer a conflict-free face-to-face assessment tool to determine level of care (non-financial eligibility) for EPD Waiver services. Additionally, changes were made to elect the Spousal Impoverishment option under Appendix B to determine a person's eligibility for services, and modify the service delivery parameters for participant-directed-services, which is an already approved service delivery method under the existing Waiver.

The major changes are as follows:

The Waiver Amendment introduces three new services- adult day services, and occupational and physical therapy services.

Adult day health services will enable persons enrolled under 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. These providers will be compliant with all the new HCBS "setting" requirements pursuant to the District's new Provider Readiness Review process.

Occupational therapy and physical therapy services were added to be provided by licensed professionals under a Home Care Agency or by licensed individual practitioners

The personal care aide service description will be modified to mirror the PCA Service Authorization request and submission procedures in accordance with the District's Medicaid Sate Plan PCA services rulemaking (Chapter 50 of Title 29 of the DCMR) to include the utilization of a face-to-face standardized needs-based assessment tool that determines each person's level of need for services. Changes were also made to allow the order for PCA services to be signed by an advance practice registered nurse (APRN) or a physician; conduct beneficiary re-assessments every twelve (12) months to update plans of care; and eliminate any annual caps for the receipt of services.

Homemaker and chore aide service descriptions were amended to clarify the existing language under the service. A new provider category – general business providing housekeeping services in the District of Columbia – will be added to the list of allowable providers of homemaker and chore aide services. The training criteria for chore aides were also amended.

The Environmental Accessibility Adaptation (EAA) service description was modified to amend the requirement that both renters and certified home-owners need to initially obtain a denial letter from Handicap Accessibility Improvement Program (HAIP), administered by the District of Columbia Department of Housing and Community Development prior to applying for EAA services under the Waiver, as HAIP is only applicable to certified home-owners. Although no change to the total rate is proposed, the disaggregated cost limits associated with each type of EAA modification was removed. The limitations on amount, duration, and scope are to be modified to clarify that the total rate is inclusive of costs associated with the home inspection.

Case management and person-centered planning requirements were amended to conform to the new HCBS standards under the federal regulations. These include that any new entity cannot enroll as a Medicaid reimbursable provider of case management services if that entity is a Medicaid provider of personal care aide (PCA) services or any other direct services under the EPD Waiver, or has a financial interest, as defined under 42 CFR §411.354, in a Medicaid provider of PCA or any other direct services under the EPD Waiver. Additionally, person-centered planning needs to be "person-driven" and focus on the needs, strengths, goals, and preferences of the person receiving services.

The case management rate reimbursement methodology was changed to a new Per Member Per Month (PMPM) payment structure. The capitation rate approach will provide a better correlation between reimbursements and the number of beneficiaries receiving case management services.

The Transition Plan included under Attachment # 2 explains the assessment, compliance, and monitoring processes that the District will undertake to ensure that assisted living facilities will conform with all the new setting requirements prescribed under 42 CFR 441.301.

The new service delivery method describes the District's Memorandum of Agreement (MOU) between DHCF and the Office on Aging (DCOA), which designates DCOA's Aging and Disability Resource Center as a one-stop-resource to provide information, referral and assistance, options counseling for persons enrolling in the EPD Waiver. It also changes the processes for eligibility under the EPD Waiver by designating a DHCF LTCSS Contractor to make all level of care determinations by conducting a face-to -face assessment of the individual's physical, cognitive and behavioral health care and support needs, to determine the individual's level of need for Waiver services and supports.

The eligibility section was amended by electing to use spousal impoverishment rules to determine eligibility for the home and community-based waiver group, whereby a certain amount of the couples' combined income and assets are protected for the spouse not receiving services under the HCBS waiver, to be effective in EPD HCBS Waiver Year 4, or upon approval by CMS.

The Amendment modifies service definitions for participant-directed community supports (PDCS) (under employer

authority) and individual-directed goods and services (under budget authority). Waiver participants who choose to self-direct these participant-directed services (PDS) will have choice and control over how they are provided and by whom. Under employer authority, waiver participants or their authorized representatives, as appropriate, will be the common law employer of the qualified participant-directed workers (PDWs) they hire. Financial management services (FMS) and information and assistance (I&A) supports will be provided to waiver participants who choose to self-direct the aforementioned PDS through a District-wide, IRS-approved Vendor Fiscal/Employer Agent (VF/EA FMS) FMS-Support Broker entity and will be provided as administrative activities. The VF/EA FMS-Support Broker entity will operate in accordance with Section 3504 of the Internal Revenue Code and Rev. Proc. 70-6, as modified by REG-137036-08 and Rev. Proc. 2013-39.

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**	
☑ **Appendix B – Participant Access and Eligibility**	
☑ **Appendix C – Participant Services**	
☑ **Appendix D – Participant Centered Service Planning and Delivery**	
☑ **Appendix E – Participant Direction of Services**	
☑ **Appendix F – Participant Rights**	
☑ **Appendix G – Participant Safeguards**	
☑ **Appendix H**	
☑ **Appendix I – Financial Accountability**	
☑ **Appendix J – Cost-Neutrality Demonstration**	

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 Renewal 01/04/2012

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
Waiver Number:DC.0334.R03.01
Draft ID: DC.003.03.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/04/12
Approved Effective Date of Waiver being Amended: 01/04/12

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 in42 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:
NA

○ **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 Eligiblity 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 Elderly and Individuals with Physical Disabilities (EPD) Waiver serves individuals who are age sixty-five (65) and over, and individuals with physical disabilities ages eighteen through sixty four (18 – 64) 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, adult day health services to maintain people at home including those that are participant-directed that will be enable them to reside in their homes while receiving assistance with their activities of daily living.

OBJECTIVES:

1) Ensure the target populations remains in home and community-based settings that meet all of the requirements of the HCBS regulation under 42 CFR 441.301.
2) Ensure that 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 agreement with DHCF.

1) The District of Columbia's Office on Aging's 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. 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 need assessment, which is 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, and secures 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.

11) The CMA's case manager contacts the applicant and creates a person-centered service plan to address all of the needs of the applicant.

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

Additionally, all persons enrolled in the EPD waiver will be afforded the opportunity to self-direct the following services: participant-directed community support (PDCS) and individual-directed goods and services. Waiver participants who choose to self-direct these services will 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 will provide financial management services (FMS) and information and assistance (I&A) supports as administrative activities.

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. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

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

- [ ] **Geographic Limitation.** A waiver of statewideness 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 statewideness 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 in-patients 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 and information on the development of the Waiver from its inception. Specifically, case managers, providers, and community advocates are invited to monthly EPD Waiver meetings. In the meetings the attendees were informed of the renewal process and continued services in the EPD Waiver The attendees were asked to forward any issues, concerns and or recommendations to DHCF/DLTC. Providers and Advocates were informed to provide feedback on the change to separate case management and direct care services.

Additionally, the following forums/trainings were also held to elicit comments for the proposed Waiver Amendment:

· Five trainings on HCBS settings rule, held in January 2014 (DHCF internal staff including the Executive Management Team), February 2014 (EPD Waiver Providers), April 2014 (EPD Waiver and Adult-Day Providers), November 2014 (Adult-Day Providers); and January 2015 (HCBS Stakeholders Group).
· Monthly meetings with PDS Stakeholders Group, include representatives from the DC Coalition for LTC and its Participant-directed Care (PDC) Taskforce; representatives from the DC CIL, Legal Counsel for the Elderly and the DC LTC Ombudsman; representatives from the disability advocacy group Direct Action, self-advocates with physical disabilities, a daughter of an elder and a father of a person with a physical disability, two senior advocates, representatives from the home health industry, and representatives from DHCF and DDS (launched in Spring 2014)
· HCBS Stakeholder Subgroup on Transition Plan—met weekly Jan-Feb, will reconvene upon CMS approval of transition plan to focus on implementation
· HCBS Stakeholder Subgroup on Person-Centered Planning—Met weekly Jan-Feb, will reconvene in June (upon submission of EPD waiver) to develop and implement training approach for PCP
o January 21—hosted in-service on PCP
· HCBS Stakeholder Subgroup on Conflict-free Case Management—Met weekly Jan-present, focused on EPD waiver, business work flow, training, and implementing Community of Practice
· HCBS Transition Plan
o thirty (30) day public comment period (closed March 13, 2015)
o public forum (February 26, 2015)

The following information was added pursuant to the District Informal Questions period- DHCF shared the sections regarding rate determination methods as a component of its public comment period. DHCF also communicated 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 in regards to the rates or rate methodologies outlined

in the EPD Waiver. Given that no comments were received, there were no associated changes made to the proposed rates or rate methodologies.

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:	Mary
First Name:	Devasia
Title:	Interim Director, Administration of Long Term Care
Agency:	Department of Health Care Finance
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Address 2:	
City:	Washington
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E-mail:	mary.devasia@dc.gov

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

Last Name:	NA
First Name:	
Title:	
Agency:	
Address:	
Address 2:	

City:	
State:	**Dist. of Columbia**
Zip:	
Phone:	**Ext:** **TTY**
Fax:	
E-mail:	

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:	Claudia Schlosberg
	State Medicaid Director or Designee
Submission Date:	Oct 14, 2015

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

Last Name:	Schlosberg
First Name:	Claudia
Title:	Deputy Director - Medicaid
Agency:	Department of Health Care Finance
Address:	441 4th Street NW, Suite 900 South
Address 2:	
City:	Washington DC
State:	**Dist. of Columbia**
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Attachments

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 renewal is a continuation of the existing waiver.

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

Section I: Purpose
The Centers for Medicare and 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 statewide 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.
The District 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, run by the District's Department of Disability Services (DDS). 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. The IDD waiver program provides residential, day/vocational and other support services in the community for District residents with intellectual and developmental disabilities.

Below is the District of Columbia's Statewide Transition Plan for the HCBS waiver services. (The IDD Waiver-specific details are located in Appendix 1, page 13, and are incorporated by reference to this Statewide Transition Plan.) To assist in the development of the plan, DHCF formed a HCBS Stakeholder Subgroup: Transition Plan, which was comprised of individuals from the DC Senior Advisory Coalition; VMT Home Health Agency; Lisner Louise Dickson Hurt Home; DC Long-Term Care Ombudsman Legal Counsel for the Elderly; Premium Select Home Care, Inc; District of Columbia Health Care Association; DC Office on Aging; DC Department of Health; DC DDS; and KBC Nursing Agency & Home Health Care Inc.

This group met weekly January-February of 2015 and served as a mechanism for DHCF to receive feedback and input from stakeholders. Once the plan was drafted, DHCF posted the plan in its entirety on the Department of Health Care Finance (DHCF) website at www.dhcf.dc.gov on February 5, 2015, and at the same time, published a notice on our website announcing a period of public comment. The plan and notice of the public comment period were further disseminated to over 60 people connected to DHCF's HCBS Stakeholder Group, to the Medical Care Advisory Committee list-serve of over 50 individuals and organizations, and shared via the DC Developmental Disabilities Council (DDC) community list-serv, which includes over 500 recipients. Approximately two-thirds of the recipients are from the community side (i.e., District residents with disabilities, family members, activists, and representatives from community-based & non-governmental organizations). The plan and public notice of the comment period were also published in the District of Columbia Register on February 13, 2015, and then re-posted on DHCF's website February 23, 2015. The public comment period ran from February 5 to March 13, 2015.
DHCF also hosted a public forum at the DC Department of Health Care Finance at 441 4th St, NW, Washington DC, 20001 on Thursday, February 26, 2015, at 4 pm in the Main Street conference room (North Building, 10th floor), at which time DHCF explained the transition plan and received oral or written comments. Notice of the public forum was posted on DHCF's website and was disseminated via email to individuals and stakeholder organizations. DHCF reviewed all comments and incorporated appropriate suggestions, as appropriate. DHCF has summarized the changes made to the transition plan in response to the public comment, and will post the summary of public comments and responses on its website by March 20, 2015.
This revised version of the Transition Plan, dated March 16, 2015, reflects the public comments received during the public comment period and continuing guidance from CMS. Changes are largely focused on including more details on dates for key activities within the Transition Plan; including metrics around the number of individuals and settings impacted by the Rule; details on DHCF's heightened scrutiny process; and added opportunities for training on the Rule. The revised Plan will be posted, in its entirety, on the DHCF website by March 20, 2015.
DHCF appreciates all of the public feedback we received and the ongoing work of our HCBS Stakeholder Subgroup: Transition Plan. If you are interested in participating in this group, please contact Trina Dutta at trina.dutta@dc.gov or (202) 719-6632.
Section II: District of Columbia Initiatives to Increase Opportunities for Community Integration
A. Training and Capacity Building
The District of Columbia is engaged in a variety of efforts to build capacity across multiple agencies and among our provider community to support the full inclusion and integration of individuals in need of long term care services and supports into community settings. Listed below are some examples of ongoing initiatives that build capacity and support compliance with the HCBS Settings Rule.
• Funded by a grant from the federal Administration on Community Living (ACL) and the Centers for Medicare and Medicaid Services (CMS), four District agencies (the Department of Disability Services (DDS), the Department of Health Care Finance (DHCF), the Aging and Disability Resource Center (ADRC) within the District of Columbia Office on Aging (DCOA), and the Department of Behavioral Health (DBH)) are collaborating to develop a plan to implement a No Wrong Door (NWD) system to streamline and facilitate access to long term care services and supports (LTCSS). A major emphasis of the District's planning activities is optimizing informed choice and promoting person-centered thinking and planning among District agency staff and service providers. The new system will be supported by a robust information management system that will optimize individual choice, person-centered planning and self-direction, and community integration.

• DHCF has been implementing a multi-year, multi-pronged strategy to reform Medicaid-funded long-term care services and supports. The first phase of this effort focused on the development and implementation of a standardized assessment tool and a conflict-free, face to face assessment process. The tool is designed to assess an individual's needs across multiple domains, rather than determining eligibility for a particular service or service setting. The tool provides the individual with a score that allows them to choose from a range of LTCSS options.

• DHCF and DCOA recently entered into Memoranda of Understanding designed to increase collaboration between DHCF

and DCOA and strengthen the role of DCOA in providing choice counseling and application assistance to District residents and their families who are seeking LTCSS.

• DHCF has established a workgroup (comprised of DHCF, DCOA/ADRC, the Department of Health, the Economic Security Administration, etc.) to analyze workflows associated with the LTCA. The workgroup's efforts seek to modernize business processes to facilitate the application process, and issues identified by this workgroup are flagged and remedied.

• DHCF, working in conjunction with CMS consultants, on January 21, 2015 hosted an in-service on person-centered planning for DHCF stakeholders, and will continue to work with the technical assistance providers both for planning and training purposes addressing person-centered planning and conflict-free case management. These trainings will focus on DCOA staff and DHCF staff, as well as Medicaid case managers and other staff and stakeholders in the community. The consultants will work with DHCF staff to develop a Community of Practice for DC Medicaid case managers focused on supporting and facilitating greater individualized community exploration and integration. The Community of Practice will allow for multi-directional training and information sharing: from District government to case managers; from case managers to District government; and amongst case managers. This Community of Practice will launch in Fall 2015.

• DHCF has engaged District staff, community stakeholders, and Medicaid service providers on the HCBS settings rule, with five trainings held in January 2014 (DHCF internal staff including the Executive Management Team), February 2014 (EPD Waiver Providers), April 2014 (EPD Waiver and Adult-Day Providers), November 2014 (Adult-Day Providers); and January 2015 (HCBS Stakeholders Group).

B. DHCF Waiver and State Plan Amendment Activities

DHCF is working to increase access to home and community-based services. DHCF is working on amendments to its 1915 (c) waiver and other state plan services. Specifically, DHCF recently obtained approval of a new 1915(i) State Plan Amendment to establish an adult day health program. Listed below are examples of changes that support and facilitate greater individualized community exploration and integration.

EPD Waiver Amendment

DHCF is in the process of drafting amendments to its EPD Waiver, with plans to submit to CMS by June 15, 2015. The Department is revising its service descriptions for assisted living, homemaker, chore aide, personal care aide, participant directed services, case management, and environmental access adaptation services in order to better support and facilitate greater individualized community exploration and integration. In particular, the assisted living service description will incorporate specific requirements in the HCBS settings rule (including requirements around provider self-assessment of compliance), and the case manager service description will include mandatory assessment of settings relative to the HCBS rule. For all services, DHCF is revising the associated outcomes measures, as well, which will include measures related to supporting and facilitating greater individualized community exploration and integration. DHCF is also including provisions to increase the array of sanctions that DHCF may impose if a provider is out of compliance with one or more standards. DHCF will provide opportunity for a 30-day public comment period and will host at least one public meeting to explain the EPD Waiver Amendment in plain language and answer any questions. DHCF will notify the public of the 30-day public comment period and the public meeting(s) by via notice in the DC Register in April 2015.

DHCF State Plan Amendment

DHCF obtained approval of its new 1915(i) State Plan Amendment to establish an adult day health program (ADHP) on February 10, 2015. ADHPs provide essential services including social service supports, therapeutic activities meals, medication administration, and transportation to therapeutic activities for adults, age fifty-five (55) and over, during the day, in a safe community setting outside of their home. All AHDP providers will be compliant with the HCBS settings rule from launch of the 1915(i), which is set to start June 1, 2015.

In addition, DHCF is amending its State Plan with respect to Home Health Care and Personal Care Assistance Services. The amendments are designed to clarify and strengthen program requirements to promote community exploration and integration, among other things.

Section III: DHCF collaboration with Government Partners

A. Office on Aging

DHCF has entered into several Memoranda of Understanding with the District's Office on Aging (DCOA) that will support and facilitate greater individualized community exploration and integration. DCOA is responsible for advocating, planning, implementing, and monitoring programs in health, education, employment, and social services which promote longevity, independence, dignity and choice for District of Columbia residents 60 years of age and older and persons 18 years of age and older with disabilities. DCOA operates the Aging and Disability Resource Center (ADRC), a one-stop resource, providing information, referral and assistance; options counseling; and person-centered planning for persons seeking long term care services and supports. As a part of its information, referral and assistance services, DCOA's ADRC conducts a preliminary intake and pre-screening and assists individuals with applications for public benefits including Medicaid

programs and services, i.e. the EPD Waiver, 1915(i) State Plan services and other public benefits. DCOA's ADRC is also the Local Contact Agency (LCA) for individuals in nursing homes who, in response to Section Q of the Minimum Data Set (MDS) that nursing homes are required to complete, indicate an interest in living outside of the nursing facility.
The purpose of these MOUs is to coordinate and share data in an effort to ensure that DCOA's ADRC can provide application assistance, options counseling and person-centered planning to individuals who are seeking or receiving long-term care services and supports who are current Medicaid beneficiaries or who may be eligible for Medicaid. Further, these MOUs ensure that individuals currently living in nursing homes who are medically able, Medicaid eligible, and express an interest in moving into the community are afforded the full range of necessary resources in order to effectuate a return to the community as quickly as possible. To that end, the ADRC Community Transition Team (CTT) provides transition coordination services for these nursing home residents. In November 2014, the District consolidated its nursing home-to-community transition coordination units at the ADRC. The consolidation represented a merger of DC's Money Follows the Person (MFP) transition coordination unit, previously housed at DHCF under the MFP Demonstration, and a transition coordination unit already housed at the ADRC.
This level of collaboration between the agencies, including the sharing of data, is necessary in order to complete and track required assessments and identify needs, assist with the eligibility determination process, support educated options counseling about Medicaid services and community supports, and satisfy all legal requirements while helping District residents attain or maintain their independence in the most integrated setting appropriate to their needs and preferences.
B. Department of Health
In addition to DHCF's collaboration with DCOA, DHCF is also working with the District's Department of Health (DOH) to ensure that the HCBS settings qualities and requirements are incorporated into the District's regulatory requirements for community-based residential settings. DOH's responsibilities include identifying health risks; educating the public; preventing and controlling diseases, injuries and exposure to environmental hazards; promoting effective community collaborations; and optimizing equitable access to community resources. Within DOH, the Health Regulation and Licensing Administration (HRLA) protects the health of the residents of the District and those that do business here by fostering excellence in health professional practice and building quality and safety in health-systems and facilities through an effective regulatory framework.
Specifically, DHCF is working with DOH/HRLA's Intermediate Care Facilities Division (ICFD) which licenses group homes for persons with intellectual, developmental and physical disabilities residing in the District of Columbia. The ICFD also licenses Home Care Agencies, Community Residence Facilities, and Assisted Living Residences to ensure their compliance with local licensure requirements. In this role, HRLA staff inspects licensed health care facilities and providers who participate in the Medicare and Medicaid programs, responds to consumer and self-reported facility incidents and/or complaints, and conducts investigations. When necessary, HRLA takes enforcement actions to compel facilities and providers to come into compliance with District and Federal law. DHCF and DDS are working with HRLA to revise the regulations for community residential facilities which incorporate both licensed small group homes known as community residence facilities and assisted living residences. The revisions specific to the community residence facility regulations will be promulgated with a formal opportunity for public comment. Final publication is anticipated in FY 2015. In FY 2016, DOH will draft regulations relative to Assisted Living Residences that support compliance with the HCBS settings rule.

Section IV: Assessment Process, Remedial Strategy, and Monitoring and Compliance
Heightened Scrutiny Process
DHCF does not have any settings in a publicly or privately-owned facility that provide inpatient treatment; or on the grounds of, or immediately adjacent to, a public institution. It is DHCF's best estimate that DC's residential settings do not have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.

If, based upon review of assessment data, DC determines that one or more of our settings have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS; and DHCF projects that this will not be cured by March 17, 2019 via remediation (changes in service definition, regulations, certification, etc.), DHCF will either: (1) determine that the setting does not meet the HCBS Settings Rule and will transition people to a new provider and eliminate the setting from the program; or (2) submit evidence to CMS for heightened scrutiny review.

A. Assessment Process
DHCF estimates that all of our settings are at least partially compliant with the Rule, and conducted an extensive, systematic legal analysis of the laws and rules regulating the settings impacted by the HCBS settings rule, namely settings comprised of assisted living residences (Assisted Living Residence Regulatory Act of 2000, effective June 24th, 2000, (D.C. Law 13-127, D.C. Official Code §§ 44-101.01-44-108.03) and community residence facilities (D.C. Mun. Regs. 22-B DCMR §§ 3401-3499; D.C. Mun. Regs. 22-B38 DCMR §§3800-3899). While DC regulations often mirror or have equivalent federal requirements, some components of the District regulations do not comport with the new federal HCBS settings requirements. Therefore, DHCF's specific actions for coming into compliance include:

• Identify regulations that do not comport with federal HCBS requirements,
• Work with DOH to promulgate new regulations to revise and strengthen HCBS settings requirements,
• Conduct provider training and stakeholder outreach on new regulations, and
• Monitoring.

DHCF will be developing a settings self-assessment tool for use by HCBS providers, and will use CMS' "Exploratory Questions to Assisted States in Assessment of Residential Settings" as a guide in developing this self-assessment. Operators that participate in Medicaid will be expected to conduct this self-assessment either as part of their initial application process to become DC Medicaid Providers, or as part of their re-enrollment process (whichever comes first). DHCF will work with its HCBS Stakeholders Subgroup: Transition Plan to develop the tool, criteria/scoring process, implementation approach, and associated remedial actions. DHCF will conduct provider training on use of the tool in August 2015, and will begin administering this self-assessment tool in September 2015.

A high level summary of DHCF's legal analysis are set forth in Table 1.
Table 1. Legal Analysis of HCBS Settings Regulations compared to DC Regulations
CMS HCBS Setting Requirements Do DC Regulations Meet Federal HCBS Standards?
Community Residence Facilities Assisted Living Residence Community Residence Facilities for Mentally Ill Persons
The setting is integrated in and supports full access to the greater community Yes Yes No
Is selected by the individual from among setting options Yes Yes Yes
Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint Yes Yes No
Optimizes autonomy and independence in making life choices No Yes No
Facilitates choice regarding services and who provides them No No No
The individual has a lease or other legally enforceable agreement providing similar
protections Yes Yes Yes
The individual controls his/her own schedule including access to food at any time No No No
The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit No No No
The individual can have visitors at any time No No No
The setting is physically accessible Yes Yes Yes

With regard to those settings impacted by this rule, there are sixteen (16) Department of Health regulated assisted living residences in the District. Of these, three (3) are Medicaid waiver-approved ALR providers and they served 39 unique individuals in 2014. There are four (4) Department of Health regulated community residence facilities for the elderly and physically disabled in the District.

B. Remedial Strategy
Implementing Revised State Regulations to Support the HCBS Settings Requirements
As a result of the revisions noted above, 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 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). Please note that DHCF will work with DOH to train staff on the new HCBS settings rules within three (3) months of the rules being promulgated.
Partnering with Department of Behavioral Health
DHCF is in discussions with the Department of Behavioral Health regarding revising regulations for community residence facilities for mentally ill persons to comply with the Rule. This component of the transition plan will be completed by October 1, 2015. DHCF will include this information in an amendment to the D.C. HCBS Waiver Transition Plan, and will follow the requirements for public notice and input for amendments to the Plan. DHCF expects to file the first update to the Transition Plan by March 1, 2016.
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 March 30, 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 and 1915(i) providers. Additionally, DHCF has developed an addendum to the conflict-free assessment tool with the HCBS Setting rule requirements for prospective 1915(i) applicants.
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 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.
C. Monitoring and Compliance

• As a result of the revised regulations, DOH will account for the added requirements relative to HCBS settings during its monitoring process of ALRs and CRFs. At present, providers must have their DOH license renewed annually (within 90 days of license expiration). The renewal requires that a surveyor or team of surveyors (depending on the type/size of provider) make an unannounced site visit which includes three stages. First, the surveyors will observe staff interaction with individuals receiving HCBS services, assess whether the environment is in compliance with the regulations, and interview staff and clients. Then, the surveyors begin record verification, with includes reviewing medication administration, employment records, and policies and procedures. From this information, the surveyors make a compliance decision to determine if there are any deficient practices, which will be shared with the provide during the site visit exit interview. A written report detailing results of the site visit and the observed deficiencies is shared with the provider within ten days of the exit interview, and the provider then has ten days to respond with a corrective action plan. Upon receipt and approval of the plan, DOH may conduct an unannounced follow up site visit to ensure that the corrective action plan is being adhered to. This monitoring process will account for compliance with the HCBS settings rule and associated policies and procedures of the provider/licensee. Please note that DHCF will work with DOH to train staff on the new HCBS settings rules within three (3) months of the rules being promulgated.

• DHCF's EPD Monitoring Team has a comprehensive monitoring tool for all EPD waiver services which has a specific section dedicated to assisted living services. This section will be amended to reflect the HCBS settings requirements. The EPD Monitoring Team will also use the aforementioned Readiness Checklist for renewals of assisted living providers' status as EPD Waiver providers. This Checklist will be implemented by September 2015.

• Beyond DHCF's efforts to monitor enrolled Medicaid providers, the LTCA engages in an assessment process for the level of need for beneficiaries who receive long term care services and supports, as mentioned above. On June 6, 2014, DHCF published a notice of public rulemaking in the DC Register establishing standards governing the Medicaid assessment process and to establish numerical scores (via use of a standardized needs assessment tool) pertaining to the level of need necessary to establish eligibility for a range of services. DHCF received and incorporated comments and is in the process of publishing a second notice of public rulemaking. DHCF is augmenting the assessment tool to include an addendum regarding the HCBS settings requirements and qualities, using the CMS "Exploratory Questions to Assist States in Assessment of Residential Settings" as a guide. Note that this assessment tool is also used for beneficiaries' annual re-enrollment process. DHCF expects the second and final notice of rulemaking will be published by April 2015.

• EPD assisted-living service providers deemed noncompliant with the HCBS settings rule will be notified of areas of deficiency and given 30 days to submit a corrective action plan to DHCF. DHCF will utilize this corrective action plan as a component of ongoing monitoring processes. If the provider continues to be non-compliant, DHCF will evaluate the appropriateness of various sanctions as established by DHCF's amended rules. In the event that people must be transitioned from one provider to another because the provider setting does not comply with the HCBS Settings Rule, DHCF will coordinate transitions and ensure continuity of services in accordance with DHCF's Transition policy and procedure. Enforcement of compliance rules will launch September 2015.

• DHCF will issue a transmittal informing all providers of DHCF's expectations that they will come into compliance with the HCBS Settings Rule. The transmittal will be issued prior to June 15, 2015.
Section VI: Ongoing Outreach and Engagement
• DHCF sought stakeholder input form the HCBS Stakeholder Sub-Group: Transition Plan to adjust, as needed, the draft transition plan prior to publication for public comment.

• DHCF provided public notice through multiple venues to share the Statewide Transition Plan with the public, including but not limited to: (1) published notice in the DC register; (2) publication on the DHCF website; (3) email alerts to over 500 individuals and DHCF Stakeholders; and (4) announcement at existing meetings.

• DHCF posted the entire Statewide Transition Plan on its website and made it available in hard copy upon request and at all public meetings when its contents were under discussion.

• DHCF hosted one public meeting to explain the HCBS Settings Rule and this transition plan in plain language, and answer any questions. Oral comments on the plan from attendees at this meeting were be recorded and accepted as public comments.

• There was at public comment period that ran from February 5 to March 13, 2015. During that time, DHCF received 72 comments on the Transition Plan.

• DHCF accepted comments in a variety of formats, including in person, and by email and mail or fax submission.

• DHCF responded to all public comments received and made changes to the Statewide Transition Plan, as appropriate, based on those comments.

• DHCF will publish the public comments and responses on its website by March 20, 2015, and will store the comments and responses for CMS and the general public.

• The HCBS Stakeholder Subgroup: Transition Plan, which was engaged throughout the process of drafting the Transition Plan. Upon EPD Waiver Amendment submission to CMS, the subgroup will be engaged in development of assessment tools and training, as appropriate.

• All activities related to the Statewide Transition Plan were done in partnership with sister District agencies, in particular the Department of Disability Services (DDS), the Department of Health (DOH), the Deputy Mayor's office (DM), and the Office on Aging (DCOA).

The State assures that the settings transition plan included within this waiver amendment or 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):

Continued from Appendix B, Quality Improvement Strategy:

The agency will provide for an evaluation and periodic re-evaluation at least annually that each participant's level of needed care is equal to a nursing home level of care. When there is a reasonable indication that individuals might need nursing home services in the near future (one month or less) but for the availability of Home and Community-Based Services, an initial assessment and annual reassessment are performed to determine the level of assistance the participant will need. The level of care will assess the following activities:

1. Bathing
2. Dressing
3. Overall mobility
4. Eating
5. Toilet use
6. Medication management
7. Meal preparation
8. Housekeeping
9. Money Management
10. Using telephone

Activities of daily living (ADLs) are noted as items one through five. Instrumental Activities of Daily Living (IADL) include items six through ten. The following levels of need will be assigned to each ADL and IADL for each potential participant:
1) Independent – (needs no help)
2) Supervision of Limited Assistance (needs oversight, encouragement or cueing or highly involved in activity but needs assistance.
3) Extensive Assistance or Totally Dependent (cannot perform without help from staff or cannot do for oneself at all)

Minimum Standard:
1) All participants must require category 2 or 3 assistance with ADLs and IADLs
2) Assistance with at least 2 ADLs and 1 IADL is required to maintain health and welfare
Individuals are informed of any feasible alternatives under the waiver and given the choice of either institution or home and community-based services.

Through the amendment, DHCF's long term care services and supports contractor will determine non-financial eligibility (level of care) by conducting a face-to -face assessment. This assessment will utilize a standardized assessment tool which will include an assessment of the individual's support needs across three domains including: (1) functional; (2) clinical; and (3) behavioral.
1) Functional- impairments including assistance with activities of daily living such as bathing, dressing, eating/feeding;
2) Clinical supports-skilled nursing or other skilled care (e.g., wound care, infusions), sensory impairments, other health diagnoses; and
3) Behavioral- ability to understand others, communications impairments, presence of behavioral symptoms like hallucinations, and/or delusions.

The tool also documents a person's, strengths and preferences, available service and 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.

A reassessment will be conducted at least annually, or subsequent requests for reassessments can be made by the person seeking services, the person's representative, family member, or health care professional based upon a change in the person's condition, or at the time of re-assessment.

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:
   The Department of Health Care Finance, Division of Long Term Care (DLTC)
   (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 utilizes a Quality Improvement Organization (QIO) for some waiver operational and administrative functions. The QIO functions for the waiver are:
*Review and determine Nursing Home Level of Care.
*Review EPD Waiver applications (new admissions, re-certifications, and change requests)
*Prior-authorizes EPD Waiver services

The QIO, as part of the prior authorization process, performs a service plan review, to determine if the service plan and the services required are appropriate to the needs of the participant and if the services are correctly identified.

The Waiver Amendment will update the information above as follows-

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 administers face-to-face assessments to determine participants' level of care by conducting a face-to -face assessment of the individual's physical, cognitive and behavioral health care and support needs. The assessment tool will also document the person's strengths and preferences, available service and housing options and availability of unpaid caregiver support required to meet the applicant's need for assistance.

DHCF utilizes a Quality Improvement Organization (QIO) for some waiver operational and administrative functions. The QIO functions for the EDP Waiver are to do the following: 1) prior authorize EPD Waiver services; 2) review the person-centered individualized service plans (ISPs), and; 3) 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 Contracting Officer Technical Representative (COTR) for all contracted entities working on behalf of the District. The COTR is responsible for oversight and the assessment of performance of the Contractor. The

QIO is the contractor responsible for the identified portions of the waiver administration and contracted operations.

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:
The method that is used to assess the performance of the QIO is a monthly Performance Review tool that includes myriad metrics including timeliness measures, denial rates, and appeal rates. The primary measure of note is a 95% timeliness rate for waiver prior authorization review within 5 business days. Performance is reviewed on a past-month basis.

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 State's quality improvement strategy, provide information in the following fields to detail the State's 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:
Percent of federally approved slots in the EPD waiver (denominator), filled with waiver enrollees (numerator).

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:
	☐ **Other** Specify:	

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: QIO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of participants in the EPD waiver (denominator) who meet nursing home level of care criteria (numerator).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports generated by the 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 =
☑ **Other** Specify: QIO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of participants in the EPD waiver (denominator) who meet financial eligibility standards for participation in the EPD waiver (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 *(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**	☐ **Annually**	☐ **Stratified**

Specify: FMS		Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Sampling approach: Other: Convenience sample of 30 enrollees chosen at random using automated random selection program
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Sampling approach: Other: Convenience sample of 30 enrollees chosen at random using automated random selection program (i.e., RATSTAT or MMIS-adjunct software).

Performance Measure:
Average number of days from submission of a first prior authorization request for EPD waiver services to approval or denial of the request.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
Reports generated by QIO

Responsible Party for data collection/generation	**Frequency of data collection/generation**	**Sampling Approach***(check each that applies):*

(check each that applies):	*(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:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Average number of days from submission of a complete prior authorization request for EPD waiver services to approval or denial of the request.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of actual quarterly waiver expenditures versus projected quarterly expenditures. Actual quarterly waiver expenditures for each waiver service / Projected quarterly expenditures for each waiver services as specified in Appendix J

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:
Number and types of complaints about the EPD waiver program, in particular complaints about enrollment and prior authorization of services.

Data Source (Select one):
Program logs
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:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

While the state is responsible for the administration and operation of the entire waiver, two other entities apart from the State Medicaid agency perform key parts of the waiver enrollment and service authorization processes. These are: 1) the District of Columbia's (DC's) Department of Human Services' Economic Security Administration (ESA - formerly the Income Maintenance Administration – IMA) which conducts Medicaid eligibility determinations and financial eligibility determination for EPD waiver applicants who are

not previously enrolled in Medicaid, and 2) a contractor that the state uses to perform Level of Care and prior authorization functions, including LOC and prior authorization of EPD waiver services for the EPD waiver program. Thus, the performance measures above will provide basic operational information on how effectively and reliably these two organizations will conduct activities related to enrollment in the waiver and prior authorization of waiver services. As the above performance measures state. the state agency will review these two entities' performance no less frequently than quarterly. In addition to these performance measures, the state agency meets with the Contractor monthly and with ESA on a weekly basis. DHCF's Elders and Persons with Physical Disabilities Branch (EPPD) in the Division of Long Term Care is responsible for discovery and remediation activities related to waiver administration and oversight.

Although the performance measures have been identified, detailed specifications for their exact calculation have not yet been written. Below are the actions to be taken, responsible parties and timelines for completion of the performance activities:

1. Write detailed specifications for the calculation of each performance measure.

Responsible party: Manager, Division of Quality and Health Outcomes

Timeline: December 15, 2011

2. Write policies and Procedures for the calculation, submission and analysis of the performance measures

Responsible party: Manager, Division of Long Term Care

Timeline: January 1, 2012

3. Train ESA and Contractor in their roles in the production and submission of performance measures where applicable.

Responsible party: Manager, Division of Long Term Care

Timeline: February 15, 2012

4. Production and submission of performance measures.

Responsible party: Manager, Division of Long Term Care

Timeline: March 1, 2012,

In addition to these retrospective performance measures, the state Medicaid agency has formal weekly meetings with and nearly daily contact with DC's health care Ombudsman. The Ombudsman's office is a source of "real time" information on the workings of the waiver program through the number of and type of complaints it received about the EPD waiver program. The DC Ombudsman's office will be the source of performance measure number 8, but will also serve as a daily barometer of how well processes are working.

Review of performance measures and other monitoring data to determine whether the performance of the waiver and delegated function in compliance with the assurances is the responsibility of the Manager of the Division of Quality and Health Outcomes and the Manager of the Division of Long Term Care.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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 states' eligibility and enrollment files, prior authorization records and case management datasbase. 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:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

The Quality Improvement Strategy is not fully in place at this time. Below is the work plan DHCF will follow to fully implement the Quality Improvement Strategy, including: specific tasks to be undertaken during the waiver period, major milestones associated with each task, and identification of the entity responsible or completing the tasks. Although this full strategy will not be in place until January 2012, below are the tasks that will be undertaken in the next three months to fully develop and implement DHCF's strategy for Continuous Quality Improvement of service delivery via this waiver

Strategy for assuring Administrative Authority, specific timelines for implementing strategies, and parties

responsible for operation:

1. Identify all measures to be used to monitor waiver program performance:

Manager, Division of Quality and Health Outcomes

December 30, 2011

2. Write detailed specifications for how measures are to be calculated, by whom they will be reported, and to whom they will be reported.

Manager, Division of Quality and Health Outcomes

December 30, 2011

3. Write Policies and Procedures for staff responsible for monitoring each area of waiver assurances that describe how designated staff will monitor each area and how they will incorporate the performance measures into their monitoring.
Manager, Division of Long Term Care

December 30, 2011

4. Write Policies and Procedures for how contactor is to perform level of care determinations and prior authorization reviews, including the calculations of the related performance measures.

Manager, Division of Long Term Care

December 30, 2011

5. Negotiate and execute a Memorandum of Understanding with State's Department of Human Services ESA related to how to perform financial eligibility determinations for the EPD waiver program nd submit data necessary for State Agency monitoring.

Manager, Division of Long Term Care

December 30, 2011

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					
	☑	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 elderly and disabled persons who meet at least the functional criteria for admission to the nursing facility. Individuals that participate in the EPD waiver must live in their own private residence, apartment, or an assisted living facility when beneficiaries receive services for an approved EPD waiver assisted living facility.

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 for physically disabled individuals in the EPD waiver is age 64. The age for elderly individuals in the waiver is 65 and over. Therefore, when a 64 year-old disabled individual turns 65, they transition into the Elderly waiver category which facilitates a continuity of care.

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	4660
Year 2	4760
Year 3	4860
Year 4	4960
Year 5	5060

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	4050
Year 2	4162
Year 3	4278
Year 4	4397
Year 5	4520

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
EPSDT (Early Periodic Screening Diagnostic Treatment)
Transitions from Nursing Facilities and Hospitals to Community-Based Settings

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):*

EPSDT (Early Periodic Screening Diagnostic Treatment)

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 see approximately how many people currently participate 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) that 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. HSCSN's 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):*

Transitions from Nursing Facilities and Hospitals to Community-Based Settings

Purpose *(describe):*

The Money Follows the Person (MFP) demonstration provides federal grant funds to states to support state efforts to rebalance their long-term care systems over a seven-year period. The District, as part of its long-term care rebalancing efforts, has implemented initiatives designed to rebal¬ance its long-term care system so that through the MFP demonstration, it can transition a number of individuals from nursing home institutional settings to community-based settings.

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, local budgetary constraints, the District has begun utilization of the MFP program for this target population and today has transitioned a total of fifteen (15) individuals into the community from District of Columbia nursing homes during this calendar year and fifth year of the waiver and plans to continue with an increased number of forty (40) participants each waiver year to ensure a number of District residents who are currently in 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. Of the 15 who transitioned into the community, nine (9) of them currently participate in the EPD waiver while the other six (6) are receiving State Plan Personal Care Assistance and other community supports including substance abuse treatment, mental health supports-individual & group, HIV case management, and seniors' case management. There are currently eleven (11) transitions pending with discharges expected by December 31, 2011.

In April 2010, District of Columbia Nursing Facility MDS data reported a total facility census of 2,516. Of those nursing facility residents, 2,080 were Medicaid beneficiaries.
2010 Quarter 2 MDS data (reported by The Delmarva Foundation in October 2011 as the latest accessible data) showed 62 nursing facility residents across the District's 19 nursing facilities who reported wanting to receive home and community-based services, having a positive support person in

the community, and potential discharge in the next 90 days.
Based on the informal memo submitted to CMS, the District has revised its benchmark for the MFP EPD Waiver demonstration for 2011 through 2016 to have a benchmark of 40 transitions per calendar year. The District has, therefore, used this benchmark to determine the number of reserved slots for MFP participants for each of the waiver years beginning 2012 with the renewed waiver.

Capacity Reserved
CY/WY 2012: 40
CY/WY 2013: 40
CY/WY 2014: 40
CY/WY 2015: 40
CY/WY 2016: 40
Total MFP reservations: 200

Purpose (describe) for Waiver Amendment:
The District has implemented initiatives designed to re-balance its long-term care system so it can transition individuals from nursing facilities and hospitals to community based-settings through its Elderly and persons with Physical Disabilities (EPD) waiver program.

The federal Money Follows the Person (MFP) Demonstration provides grant funds to states to support efforts to rebalance their long-term care systems over a seven-year period. 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, the District started its utilization of the MFP program for this target population in 2011, and today has transitioned a total of eighty-three (83) residents into the community from nursing facilities. Based on performance in 2014 (25 transitions from nursing facilities to EPD Waiver Services), the District plans to transition thirty (30) participants each waiver year until the end of the Demonstration in 2017. This is consistent with the District's CMS MFP Project Team's recommendation during the January 2015 monthly status report and teleconference for the Demonstration.

ROLE OF ADRC IN NURSING FACILITY & HOSPITAL TRANSITIONS

For people transitioning from nursing facilities and hospitals, the District's Aging and Disability Resource Center under the Office on Aging, can work to meet their needs through several of its operational components as defined by the U.S. Administration on Aging:
-Information, Referral, & Awareness
-Options Counseling
-Streamlined Eligibility Determination for Public Programs
-Person-Centered Transitions.

Using a person-centered transition process, ADRC staff can conduct options counseling and transition coordination for these people. Based on decisions made by nursing home residents during the options counseling, ADRC staff can provide information about community providers and make the appropriate referrals, and if the resident chooses, through its Community Transition Team, lead the planning for discharge and the months of transition after leaving the facility.

The ADRC's Community Transition Team (CTT), originally established in 2013 as the Nursing Home Transition Unit, provides transition coordination services specifically for long-term nursing facility residents and hospital patients who want to return to the community, and need home and community-based services to do so successfully. As of the fall of 2014, the CTT acts as a consolidated transition coordination unit for the District that includes the ADRC's Transition Care Specialists, as well as the MFP Transition Coordinators previously housed at the Department of Health Care Finance.

Describe how the amount of reserved capacity was determined:

As approved in October 2010 by CMS in the MFP Operational Protocol dated 10.22.2010: Because of the limited number of MFP participant slots relative to the number of nursing facility residents who have expressed a desire to move, MFP will be implementing a lottery to select MFP participants from

the pool of MFP-eligible individuals who have met screening requirements and submitted completed required documents (initial screen and consent) that initiate the MFP enrollment process.
The opportunity for participation in the lottery will be formally announced and actively encouraged for all residents in each of the District's nineteen nursing facilities.

Paths for transition from nursing facilities to the community will be presented both via the MFP Demonstration and the EPD HCBS Waiver – with EPD HCBS Waiver participation strongly encouraged for interested residents who are not selected through the lottery. Interested applicants who may not be able to enroll in the EPD waiver because of the limited number of new unduplicated participants that the District can serve, will be processed for State Plan eligibility and will be able to participate in the State Plan Personal Care Aide (PCA) services and other community supports/options as long as they are eligible for State Plan Medicaid.

The lottery will be implemented with a progressively incremental approach. In the first month, three participants will be selected for MFP participation. Based on the transition success rate and assessment of the MFP system's capacity, additional individuals may be selected for MFP participation in subsequent months. In year one, MFP will not select more than five participants per month with the understanding that expenses will be limited by the availability of funds for services based on projected budget figures. MFP transition capacity will be formally reassessed regularly. DHCF will work with CMS to expand MFP capacity if transitions move more quickly than anticipated.

ROLE OF ADRC IN NURSING HOME TRANSITIONS FOR NON-WAIVER
For people transitioning from nursing homes who only need State Plan PCA services, the ADRC can work to meet their needs through several of its operational components as defined by the U.S. Administration on Aging:
-Information, Referral, & Awareness
-Options Counseling
-Streamlined Eligibility Determination for Public Programs
-Person-Centered Transitions.
Using a person-centered transition process, ADRC staff can conduct options counseling for these people. Based on decisions made by nursing home residents during the options counseling, ADRC staff can provide information about community providers and make the appropriate referrals.
The ADRC does this on a daily basis when it receives referrals- from MFP, and from other sources including nursing homes, the EPD Waiver unit, and direct calls from DC residents. With the supplemental funding provided by CMS and AOA to the MFP Demonstration and the ADRC for nursing home transitions and diversions, the ADRC will increasingly collaborate with the District's Long-Term Care Ombudsman's office to achieve its operational components.

(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.

For purposes of the Waiver Amendment,
The reserved capacity for each waiver year both supports the proposed MFP EPD benchmark for the remainder of the Demonstration through its scheduled end in 2017, and additional transitions from nursing facilities and hospitals by DC residents who do not participate in MFP. Analysis of DHCF data shows that transitions from nursing facilities directly to EPD Waiver and Medicaid State Plan Home and Community-Based Services outside of MFP are also limited in number, i.e. less than 50 annually.

Reserved capacity in 2018 and 2019 ensures the sustainability of nursing facility-to-community transition efforts through the EPD Waiver Program once MFP Demonstration Award funds have been exhausted.

Policies for the reallocation of unused capacity among local/regional non-state entities:

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.

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

Waiver Year	Capacity Reserved
Year 1	40
Year 2	40
Year 3	40
Year 4	40
Year 5	40

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 beneficiary requires the care furnished in a nursing facility under Medicaid verified by an approved nursing home level of care; 3) The beneficiary is 65 and older, or an adult 18 and over with physical disabilities; and; 4) The beneficiary is not an inpatient of a hospital, nursing facility or intermediate care facility for the mentally retarded.

As indicated in eligibility, there are reserved capacities set aside for the EPD waiver in the following amounts: 40 beneficiaries for MFP and 15 beneficiaries for EPSDT enrollees who age out of the program or are eligible to enroll in the EPD waiver. All services offered under the EPD Waiver are considered Qualified HCBS for the duration of the MFP Rebalancing Demonstration.
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**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional State supplement recipients**
- [x] **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)**
- [x] **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 spenddown 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 five-year period beginning January 1, 2014, 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 December 31, 2018.

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

Due to WMS system constraints on 7/20/2015, this item is selected. However, it is not applicable.

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 an entity under contract with the Medicaid agency.**

  Specify the entity:

  Performance of Medicaid Level of Care is conducted initially and upon annual reassessment by the District's Long Term Care Services and Supports (LTCSS) Contractor
- **Other**
  Specify:

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 will be performed by a Registered Nurse, Licensed in the State, hired by the 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.

DHCF's long term care services and supports contractor will determine non-financial eligibility (level of care) by conducting a face-to -face assessment. This assessment will utilize a standardized assessment tool which will include an assessment of the individual's support needs across three domains including: (1) functional; (2) clinical; and (3) behavioral.
1) Functional- impairments including assistance with activities of daily living such as bathing, dressing, eating/feeding;
2) Clinical supports-skilled nursing or other skilled care (e.g., wound care, infusions), sensory impairments, other health diagnoses; and
3) Behavioral- ability to understand others, communications impairments, presence of behavioral symptoms like hallucinations, and/or delusions.

The tool also document's a person's, strengths and preferences, available service and housing options and availability of unpaid caregiver supports 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.

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:

For all persons newly enrolled in the Waiver, the ADRC Enrollment Specialist (ES) will be assigned to assist the person with the application process for the EPD Waiver Program. The ES is also responsible for assisting the applicant to receive a level of care assessment (evaluation) using the standardized assessment tool which will be conducted by the Long-Term Care Services and Supports Contractor (LTCSS Contractor). 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. ESA receives the EPD Waiver Certification report/spreadsheet and performs the financial assessment and makes the determination of financial eligibility

The disposition of financial assessment is sent to DHCF and ADRC via a report , and eligibility notices are sent to the applicant and Healthcare Power of Attorney (POA).

The ES contacts the selected CMA on behalf of the applicant, and secures acceptance. The ES will contact CMAs until the applicant is accepted. After the joint meeting is held by the ADRC, DHCF, and CMA, the case is transferred to the CMA. The CMA subsequently contacts the applicant and creates a person-centered service plan to address the person's support needs under the EPD Waiver.

The reassessment process is similar to the initial assessment process, however, during the reassessment period, the ADHP's ES does not play a role. Instead upon reassessment, the ESA sends an automated annual renewal notice to the person enrolled in the Waiver, the person's HealthCare POA (if identified), the CM, at least ninety (90) days prior to the person's annual renewal date. Similar to the initial assessment process, the CM is also responsible for assisting the person to obtain a reassessment evaluation and for ensuring that the LOC information is transmitted to ESA. ESA is responsible for determining financial eligibility after the LOC is approved via the assessment tool during the reassessment.

Similar to the initial process, the disposition of financial assessment is sent to DHCF and ADRC via a report , and ESA then mails the EPD Waiver Approval Notice to the person enrolled in the EPD Waiver and HealthCare POA, the CMA and Service Provider. The CMA's CM contacts the person enrolled in the Waiver, and ensures that any modifications are made to the person-centered service plan during the person's annual ISP 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:

  The initial level of care reassessments will be performed at least every twelve months. DHCF may authorize the validity of the face-to-face reassessment for a period not to exceed eighteen (18) months to align the level of care assessment date with the Medicaid renewal date.

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):*

As mentioned above, ESA is responsible for sending the automated annual renewal notification to the CM, person enrolled in the Waiver, and the HealthCare Power of Attorney (if identified) at least ninety (90) days prior to the annual recertification period. The CM will subsequently assist the person enrolled in the Waiver with the reassessment (reevaluation) process. The CM ensures that the LOC information is transmitted to ESA, and ESA sends a disposition of financial assessment to DHCF and ADRC via a report and also sends notices to the person, person's HealthCare POA and the CM once the financial assessment is determined. The CM will then upload all documents into the EPD Waiver electronic management system.

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 record of evaluation and re-evaluations of records are stored in the Medicaid electronic case management system, which is maintained by the Medicaid agency in its central office.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
Number and percent of all new enrollees who have a level of care indicating need of nursing home care prior tothe receipt of waiver services. N: # of new enrollees who have a level of care indicating need of nursing home care before receiving waiver services D: # of new enrollees.

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 =
☑ **Other** Specify: Quality Improvement Organization (QIO)	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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: QIO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of applicants to the EPD Waiver (denominator) who received an evaluation for LOC during the reporting period.

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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: QIO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of applicants to the EPD Waiver program, who were denied enrollment in the EPD Waiver due to failure to show the appropriate LOC as needed.

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 =
☑ **Other** Specify: Contractor performing LOC determinations.	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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: QIO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

Performance Measure:
Number and percent of beneficiaries who received an annual re-determination of eligibility within 12 months of their initial LOC evaluation or within 12 months of their last annual LOC evaluation. N:# of beneficiaries who received an annual eligibility redetermination within 12 months of their initial or last LOC evaluation D:# of waiver beneficiaires.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIO System and 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 =
☑ **Other** Specify: QIO	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
Number and percent of beneficiaries' initial and annual LOC determination made in accord with written policies and procedures established for the contractor by the state Agency.

Data Source (Select one):
On-site observations, interviews, monitoring
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:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Sampling approach: Convenience sample of 30 enrollees chosen at random using automated random selection program
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**

☐ **Other**
Specify:

Performance Measure:
Number and percent of beneficiaries level of care determinations made where the level of care criteria was accurately applied. N:# of waiver beneficiaries level of care determinations where criteria were accurately applied D:# of level of care determinations reviewed.

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 =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Convenience sample consisting of 30 enrollees chosen at random using an automated random selection program
	☑ **Other** Specify: Semi-Annualy	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.
Appendix H: Quality Improvement Strategy 

The Quality Improvement Strategy is not fully developed at this time. Below is the work plan DHCF will follow to fully develop the Quality Improvement Strategy, including: specific tasks to be undertaken during the waiver period, major milestones associated with each task, and identification of the entity responsible or completing the tasks.

Task 1. Convene and charge DHCF Team responsible for Quality Improvement Activities. DHCF underwent a second realignment in June of 2011 (the first occurred in October of 2010), which, among other things, moved the former Office of Quality Management into the Health Care Delivery Management Administration, in which the Division of Long Term Care and its Elders and Persons with Disabilities Branch (EPDB) are located. This move was undertaken to more closely integrate quality improvement activities and a focus on health outcomes into the delivery of Medicaid services.

Simultaneous with this realignment, new recruitment activities were undertaken for key management positions responsible for this waiver. As a result, a new Director of HCDMA was hired, a new Manager of the Division of Long Term Care has been hired, and recruitment of a new manager for the EPDB is underway. All of this has transpired in the last four months.

The new Manager of the Division of Long Term Care assessed the responsibilities and work activities of all staff in the EPDB and determined that the vast majority (approximately 90%) of activities are problem-solving interventions on a beneficiary by beneficiary, problem by problem basis. Little to no measurement of delivery system performance, beneficiary experiences with care, or health status has occurred.

In the next three months, prior to the renewal of this waiver, the DLTC Manager will complete evaluations of staff function. Responsibilities for systems assessment activities and quality improvement activities will be assigned for each of the six waiver assurances. This will be done in collaboration with and using the personnel resources of the Division of Quality and Health Outcomes (Formerly the Office of Quality Management). The Division of Quality and Health Outcomes has assigned one staff person to work exclusively with the Division of Long Term Care on Quality Measurement and Improvement Activities.

Although this full strategy will not be in place until January 2012, below are the task that will be undertaken in the next three months to fully develop and implement DHCF's strategy for Continuous Quality Improvement

of service delivery via this waiver. Task completion will be directed by DHCF's Director of HCDMA and Manager of the Division of Quality and Health Outcomes, who together have substantial experience and expertise in health care quality measurement and improvement in general, and for the Medicaid program, in particular.

Task 2 Identification of desired structural features, operational processes and beneficiary outcomes for each of the following waiver assurances: evaluation of need, choice of alternatives, health and welfare, financial assurances, reporting, and expenditures, and for the participant directed services option of the waiver.

Because the design of this proposed waiver is nearly identical to that of DHCF's current waiver, DHCF staff has already identified key systems issues in which quality can be improved. These include, for example: the length of time it takes an applicant to be enrolled in the waiver (when the waiver cap has not been reached), reliability of care planning processes, coordination of the waiver service with state plan services, incorporation and encouragement of provision of care by informal supports (avoiding "crowd out"), provider knowledge of their responsibilities for case management, and case management itself. Although the few areas identified above are readily identified by staff as areas in need of improvement, DHCF will conduct its own comprehensive assessment of structural and operation safeguards and desired beneficiary outcomes that will serve as goals for the new waiver. This will be conducted through key informant interviews with DHCF staff, beneficiaries, advocates and waiver providers. For each of these performance standards, performance measures will need to be developed.

Task 3. Develop detailed specifications for measures of waiver performance for each performance standards. Too often, performance measures are unreliable indicators of quality as the specifications for calculating the measure lack validity and reliability. Once the quality standards are identified, the data sources for calculating the measures, the means of collecting the data, the specifications to be followed in calculating the measure, will need to be documented. The parties responsible for each of these activities will also be determined, as well as the frequency for the data collection.

Task 4. Develop process for feeding back measurement results to parties responsible for meeting the standard and identify incentives to be used to stimulate improvement. Measurement is necessary, but not sufficient for improving quality. Although the science of quality improvement hasn't shown how to guarantee improvement, certain activities have played a part in multiple quality improvement initiatives: the engagement of a credible and influential leader in quality improvement (QI "Champion"), feeding back measurement results to providers and sharing where a provider compares against its peers, publishing performance via a "report card" and use of financial incentives to reward goal attainment or significant improvement. Over the next six months, DHCF will determine which of these (or other) approaches it will use to stimulate quality improvement and likely that diverse and multiple incentives may need be planned to be used for different assurances.
Please see Additional Space Option in Main B.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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 District's eligibility and enrollment files, and MMIS–adjunct 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*(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**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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 State agency uses a contractor to perform Level of Care determinations. Thus, the performance measures for this assurance and related sub assurances will use data contained in the State Agency's MMIS system, and MMIS adjunct web platform used by providers to submit LOC applications to the EPD waiver program, and data from the Contractor's information system for their calculation. In addition to using performance measures to discover /identify problems /issues within the waiver program related to LOC determinations, the state agency has several other methods for monitoring problems with level of care. These include: 1) aggregation and analysis of complaints received by the State agency pertaining to LOC determinations; 2) aggregation and analysis of complaints received by the District of Columbia Office of the Health Care Ombudsman; 3) aggregation and analysis of contacts to the State agency initiated by beneficiary advocacy organizations; and 4) standing monthly meetings with the District of Columbia Long Term Care Coalition. EPPD meets with the Ombudsman on a weekly basis, and with the Coalition on Long Term Care on a monthly basis. DHCF's Elders and Persons with Physical Disabilities Branch (EPPD) in the Division of Long Term Care is responsible for discovery and remediation activities related to Level of Care Determinations.

Below is the detailed Strategy for Assuring Level of Care, the specific timelines for implementing identified strategies, and the parties responsible for its operation:

Initial LOC determinations and redeterminations will be performed by a contractor to the State agency following policies and procedures written and disseminated to the Contractor by the EPPD. This Contractor has already been procured. The Contractor (currently Delmarva Foundation, Inc.) is a federally certified Quality Improvement Organization for the federal Medicare program. In addition to performing the LOC determination process, the contractor performs a variety of utilization management processes for the Medicaid program including level of care determination for nursing facilities, as well as prior authorizations for multiple types of Medicaid services. This contract is being reprocured, in accord with District of Columbia regulations as its five–year contract period of performance has ended, Whether the current contractor will continue or a new contractor is selected will depend on the strength of the Offerors' proposals.

TASK 1: Write Policies and Procedures for conducting initial LOC determinations and re-determinations

Responsible party: Manager, Division of Long Term Care

Timeline: January 1, 2012

TASK 2: Write detailed specifications for the calculation and analysis of the performance measures

Responsible party: Manager, Division of Quality and Health Outcomes

Timeline: January 1, 2012

TASK 3: Assign production and submission of performance measures to responsible EPPD staff.

Responsible party: Manager, Division of Long Term Care

Timeline: February 1, 2012,

Task 4: Develop and implement process for feeding back measurement results to parties responsible for meeting the standard, ensuring remediation activities are implemented as needed, and following-up on system performance.

Responsible party: Manager, Division of Long Term Care

Timeline: February 1, 2012,

Overall review of performance measures and other monitoring data to determine whether the performance of the waiver complies with LOC assurances is a shared responsibility of the Manager of the Division of Quality and Health Outcomes and the Manager of the Division of Long Term Care.

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 case manager 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 DHCF's 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	Personal Care Aide
Statutory Service	Respite
Other Service	Assisted Living
Other Service	Chore Aide
Other Service	Environment Accessibility and Adaptation Services
Other Service	Individual Directed Goods and Services
Other Service	Occupational Therapy
Other Service	Participant-Directed Community Support Services
Other Service	Personal Emergency Response System (PERS)
Other Service	Physical Therapy

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:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
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.
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.

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 "setting" 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 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 ;
(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.

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:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
The conflict-free case management (CM) service is designed to ensure that the Medicaid 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 competitive and integrated settings while receiving services in the community to the same degree as people who do not receive Medicaid funded services. CM services include

only services 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 in comparison to regular CM services which 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 individual service plan for Medicaid and non-Medicaid services (including community resources) that reflects the person's strengths, interests, preferences, community and family supports, personal goals, financial resources, and assessed needs. Based on this plan, the case manager develops an Individual Services Plan (ISP) and assists the person in accessing an individualized mix of services detailed in the ISP in the most integrated community setting appropriate to his/her needs and desires, and provides ongoing monitoring of the person's use of the services and supports detailed in the ISP. Additionally, the case manager advocates on the person's behalf within service networks while ensuring the person accesses and stays connected to all public benefits for which he/she is eligible. CMs do not replace family systems and/or other community services, but augment the person's natural supports.

I. Requirements for Person Centered Planning (PCP)

The case manager shall commit to making services fit persons, rather than making persons fit services, and enable a PCP process, directed by the person 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, as possible;

(3) Incorporates 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 individual;

(4) 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;

(5) Provides meaningful access to persons and/or their representatives with limited English proficiency (LEP), 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 to 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 Individual Service Plan

The case manager shall ensure that the person-centered ISP highlights the person's strengths and that it aligns with the person's articulated quality of life goals, service and support needs, and preferences. Specifically, the person-centered ISP 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 in his or her own words, 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 and invited by the person to engage in the PCP and in monitoring the execution of the ISP;

(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 available 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); the plan must 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 a self-directed delivery system;
(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 person-centered Individual Service Plan 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 ISP (or a component of the plan, as determined by the person).
III. Implementing and Monitoring the Person-Centered Individual Service Plan (ISP)
The case manager shall work with the person to implement the person-centered Individual Service Plan. 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 ISP, 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 ISP in type, scope, duration, and frequency. If results of routine monitoring activities necessitate updates to the ISP, this should be done within ten (10) days of said monitoring activity, with approval signatures from those who participated in ISP planning and development, with mandatory signatures of the person and the case manager.
(4) Review and update the ISP 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 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 from those who participated in ISP planning and development, with mandatory signatures of 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.
1. The application for recertification should be submitted 60 days prior to the Medicaid expiration date.
2. CMs should begin working on the recertification no later than 90 days prior to the Medicaid expiration date.
(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 CM services provided. All records

must be maintained in a manner consistent with federal and 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 CM system to ensure that persons are receiving services per the plan.
IV. Conflict Free Requirements
CMs must be "conflict-free," and 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 person-centered Individual Service Plan:
(1) Conducting monthly home visits, at minimum);
(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) Coordinate 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) 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 ISP.

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, and have a Masters and one year of experience with the population, with either a degree in Social work, Psychology, Counseling, Rehabilitation, Nursing, Gerontology, or sociology 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

Waiver rules, "Home and Community-Based Waiver Services for Persons who are Elderly and Individuals with Physical Disabilities," are documented in the DC Municipal Regulations (DCMR) Title 29, Chapter 42, and specify that an individual meet one of the following requirements:

1. Masters degree and one year of experience with the population, with either a degree in Social work, Psychology, Counseling, Rehabilitation, Nursing, Gerontology, or Sociology;
2. Bachelors degree and the above current licensure and 2 years of experience with the population; or
3. A Registered Nurse can [RN] can have an Associate Degree and 3 years of experience, and current license.

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 QA 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, depending on acuity of the persons receiving services, proficiency of the case manager, and level of support (e.g., from a case

management assistant, etc.).
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 ISP, 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 ISP. The intake assessment findings and ISP must be completed within ten (10) 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 person-centered Individual Service Plan, as per participant request and/or as appropriate.
12. Development of the ISP 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 ISP is provided to the State Agency (or its designee) for approval of services recommended in the ISP. The State Agency (or its designee) will approve or disapprove the services recommended in the ISP 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 free choice of all qualified Medicaid providers of each service included in his/her written person-centered Individual Service Plan.
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 person-centered Individual Service Plan, 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 person-centered Individual Service Plan, 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.

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:
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:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
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	Home Care Agency
Agency	Licensed provider of housekeeping services

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):*
NA

Other Standard *(specify):*
1) A home care agency enrolled to provide homemaker services must 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 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.

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;
4) Maintain an updated CPR certificate; and
5) Pass a criminal background check.

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: 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 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:
Statutory Service

Service:
Personal Care

Alternate Service Title (if any):
Personal Care Aide

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Tasks include cueing, assistance with activities of daily living and 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 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.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
1) Limitations do not differ from any established under the Medicaid State Plan with the exception of the following-

(a) To be eligible for PCA services, PCA services must be included in the person's person-centered ISP, and a 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 assessment tool which equates to a nursing home level of care (or higher) including extensive assistance or total dependence with two or more ADLs.

b) PCA services under the waiver are limited to a total of sixteen (16) hours per day for seven days a week; and

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 ISP.

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 individual service 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:

1. 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.

2. Shall not include tasks usually performed by chore workers or homemakers, such as cleaning of areas not occupied by the recipient, laundry for family members, and shopping for items not used by the person, or money management.

3. Shall not be provided in a hospital, nursing facility, intermediate care facility for individuals with intellectual disability or institution for mental disease, or any other living arrangement which includes PCA services as a reimbursed service. However, persons residing in assisted living may receive services upon prior authorization by DHCF or its agent.
4. When a recipient is receiving PCA services and homemaker services from two different staff persons who are employees of the same agency, all supervisory registered nurse (RN) visits shall be coordinated so that supervisory in-home RN visits are made in accordance with waiver standards and the supervisory in-home RN visits are made by the same supervising RN at the same time.
5. When a person is receiving PCA and any adult day services (waiver or State Plan) on the same day, the combination of both PCA 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
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Statutory 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 before providing any waiver services; and

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.

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:
Statutory Service
Service:
Respite
Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
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.

Federal financial participation is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence, including a 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.

4) Respite services are limited to a maximum of four hundred and eighty (480) hours per year. Requirements 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	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:
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 is (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 assessment conducted by the R.N. 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 not less than 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 's home or primary place of residence.

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:

Assisted Living

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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:
(vii) The setting is integrated in and supports full access of individuals 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.

(viii) The setting is selected by the individual 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 individual's needs, preferences, and, for residential settings, resources available for room and board.

(ix) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(x) 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.

(xi) Facilitates individual choice regarding services and supports, and who provides them.

(xii) In a provider-owned or controlled residential setting, in addition to the qualities specified above, the following additional conditions must be met:

(1) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual 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.

(2) Each individual has privacy in their sleeping or living unit:

(3) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
(4) Individuals sharing units have a choice of roommates in that setting.
(5) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

(6) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

(7) Individuals are able to have visitors of their choosing at any time.

(8) The setting is physically accessible to the individual.

(Xii)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 individual.
(8) Include an assurance that interventions and supports will cause no harm to the individual.

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; and upkeep and improvement.

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 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):*
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;

Waiver rules "Home and Community-Based Waiver Services for Persons who are Elderly and Individuals with Physical Disabilities" DC Municipal Regulations (DCMR) Title 29, Chapter 42
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).

DOH verifies upon review and approval of initial license and every year.

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:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Chore Aide services consist of heavy house-hold 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 provider's safe entry and exit. .Ideally, the chore aide prepares the home environment so as to be safe and clean that make the way for more routine and ongoing routine 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 neither the person receiving services nor anyone else in the household, or the person's landlord, or third party payor is able or responsible for providing the service under a lease or other agreement.

Chore aide task 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	Home Care Agency
Agency	Licensed provider of chore aide services

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: 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
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

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:
Environment Accessibility and Adaptation Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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):*
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.
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:
Individual Directed Goods and Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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 ISP 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 person-centered ISP, meet the criteria listed above and are within the means of their PDS budget to purchase. Support brokers will 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 will submit the revised PDS budget to the Services My Way Program Coordinator for approval. The Program Coordinator must approve any individual-directed good or service requested. 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):*

NA

Other Standard *(specify):*

All individuals/vendors providing individual-directed goods and services must be at least 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 driving 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:

Occupational Therapy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Occupational Therapy services are designed to maximize independence, prevent further disability, and maintain health, and the person's functionality. These services should be provided in accordance with the person-centered ISP. All Occupational Therapy services should be monitored to determine which services are most appropriate to enhance the person's well-being and to meet the therapeutic goals. This is not an extended state plan service. This service may be used in addition to or in place of the state plan service if indicated as needed by the physician.

This service differs from the state plan service by provider qualifications and locations where service may be delivered. The occupational therapist, under the HCBS waiver, is not restricted to those employed by home care agencies. This service may be delivered by any licensed practitioner and is delivered in the person's home or day service setting.

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

If the person is between the ages of 18 and 21, the case manager will ensure that EPSDT services are fully utilized and the HCBS waiver service is not replacing or duplicating services. The EPD waiver unit also serves as a quality control when authorizing service plans to monitor the appropriate use of EPSDT and other State Plan services as appropriate. Services are limited to 4 hours per day and 100 hours per year. Requests for additional hours may be approved when accompanied by a physician's order or if the request passes a clinical review by staff designated by the State Medicaid Director to provide oversight on clinical 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	Home Care Agency
Individual	Licensed Occupational Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy

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

An Occupational Therapist licensed to practice occupational therapy in accordance with the requirements of Chapter 63 of Title 17 of the D.C.M.R

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

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: Provider Specifications for Service

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:
Individual
Provider Type:
Licensed Occupational Therapist
Provider Qualifications
License *(specify):*
An Occupational Therapist licensed to practice occupational therapy in accordance with the requirements of Chapter 63 of Title 17 of the D.C.M.R
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
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).

DOH verifies upon review and approval of initial license and every year.

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:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

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 Individual Service Plan (ISP) 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 will be 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, assistance with activities of daily living and instrumental activities of daily living. The scope, service authorization, and nature of these services do not differ from personal care services furnished under the State plan. The allowable tasks for personal care aides specified in the State plan apply.

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 (a) spouse or (b) parent or, if minor participant, legal guardian.

In accordance with the State Plan, all PDCS services provided by a PDW must be prior authorized in order to participate in the Services My Way program.

1) To be eligible for PDCS, a participant must:

(a) To be eligible for PDCS services, PDCS services must be included in the person's person-centered ISP, and a 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 assessment tool which equates to a nursing home level of care (or higher) including extensive assistance or total dependence with two or more ADLs.

b) PDCS services under the waiver are limited to a total of sixteen (16) hours per day for seven days a week; and

c) PDCS 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 ISP.

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 will be dictated by the amount, duration, and scope of services determined in accordance with the person'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 person'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:

1. 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.

2. 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.
3. 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.
4. 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)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **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:
a. Be at least eighteen (18) years of age;
b. 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. Laws 12-238 and 14-98), D.C. Official Code § 44-551 et seq.;
c. Receive customized training provided by the participant and/or his/her authorized representative;
d. Be able and willing to provide the service-related responsibilities outlined in the participant's person-centered ISP; and
e. Be certified in cardiopulmonary resuscitation (CPR) and First Aid and maintain current certifications.
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 will verify that PDW qualifications are met during the employment process and will execute 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 Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

PERS is an electronic device that enables certain persons at high risk of institutionalization to secure help in emergency situations by activating a system connected to the person's phone that is programmed to signal a response when a portable "help" button is activated.

Each system is comprised of three basic elements: (a) a small radio transistor (portable help button) carried by the user; (b) a console or receiving base connected to a user's telephone; and (c) a response center or responder to monitor the calls.

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

1) No PERS will be provided to persons enrolled in the waiver who live with an individual who assumes responsibility for the safety of the recipient.

2) No PERS will be provided for persons who are unable to understand and demonstrate proper use of the system.

3) No PERS will be provided to persons who live with an individual who assumes responsibility for providing care (to the person enrolled in the waiver) and the person is not left alone for significant periods of time.

4) PERS response center support must be provided on a 24-hours per day, 7-days per week basis;

5) Emergency equipment repair service must be available to the person on a 24-hours per day, 7-days per week basis; and

6) The PERS provider must allow the person to designate respondent(s) who will respond to emergency calls. Respondents may be relatives, friends, neighbors or medical personnel.

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	PERS provider - Business

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:
Agency
Provider Type:
PERS provider - Business
Provider Qualifications
License *(specify):*
Business in good standing in the District of Columbia
Certificate *(specify):*
NA
Other Standard *(specify):*
Each business or provider of Medicaid reimbursable PERS services shall have a current license, certification, or registration with the District of Columbia as appropriate for the electronic system being purchased. Each business, or provider shall also demonstrate knowledge of applicable standards of manufacture, design, and installation. In order to be eligible for Medicaid reimbursement, the 24-hour- 7 day a week emergency response center shall be monitored by trained operators capable of determining if an emergency exists and notifying emergency services and the person's respondent. Each provider of PERS shall develop and maintain an incident reporting process that requires notification to DHCF within twenty four (24) hours of a reportable emergency response.
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:

Physical Therapy

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Physical Therapy (PT) services are designed to maximize independence, prevent further disability, and maintain health, and the person's functionality.

They are also designed to treat the identified physical dysfunction or the degree to which pain associated with movement can be reduced. They should be provided in accordance with the person's individual service plan. All PT services will be monitored to determine which services are most appropriate to enhance the person's well-being and meet the therapeutic goals.

This is not an extended state plan service. This service may be used in addition to or in place of the state plan service if indicated as needed by the physician. This service differs from the state plan service by provider qualifications and locations where the service may be delivered. The Physical Therapy professional under the HCBS waiver is not restricted to those employed by home care agencies. This service is delivered by any licensed practitioner and is delivered in the individual's home or day service setting.

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

If the person is between the ages of 18 and 21, the case manager will ensure that EPSDT services are fully utilized and the HCBS waiver service is not replacing or duplicating services. The EPD waiver unit also serves as quality control when authorizing service plans to monitor the appropriate use of EPSDT and other State Plan services as appropriate. Services are limited to 4 hours per day and 100 hours per calendar year. Requests for additional hours may be approved when accompanied by a physician's order or if the request passes a clinical review by staff designated by State Medicaid Director to provide oversight on clinical 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	Home Care Agency
Individual	Licensed Physical Therapist or Physical Therapy Assistant working under direct supervision

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Health-Care and Community Residence Facility Act, Hospice and Home-Care Licensure Act of 1983, effective Feb. 24, 1984 (DC Law 5-48; DC Official Code, § 44-501 et seq), and implementing rules.

A physical therapist licensed to practice physical therapy in accordance with the requirements of Chapter 67 of Title 17 of the DCMR.

A physical therapy assistant licensed to practice as a physical therapy assistant in accordance with the requirements of Chapter 82 of Title 17 of the D.C.M.R.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

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: Provider Specifications for Service

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:

Individual

Provider Type:

Licensed Physical Therapist or Physical Therapy Assistant working under direct supervision

Provider Qualifications

License *(specify):*
A physical therapist licensed to practice physical therapy in accordance with the requirements of Chapter 67 of Title 17 of the DCMR.

A physical therapy assistant licensed to practice as a physical therapy assistant in accordance with the requirements of Chapter 82 of Title 17 of the D.C.M.R.

Certificate *(specify):*
N/A

Other Standard *(specify):*
N/A

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).

DOH verifies upon review and approval of initial license and every year.

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.*

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 recipients. Home Health Agencies serve as case management service providers and provide case management services on behalf of Waiver paticipantss. These services include conducting direct observation of the recipient, conducting a comprehensive assessment of the recipient's medical, social, and functional status to include obtainment of level of care determinations and determining and developing the recipient's ISP.

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. (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. Annually a representative sample of personnel records are reviewed 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.

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 units 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
Chore Aide	☐
Participant-Directed Community Support Services	☐
Individual Directed Goods and Services	☐
Case Management	☑
Physical Therapy	☐
Occupational Therapy	☐
Adult Day Health	☐
Personal Care Aide	☑
Homemaker	☐
Environment Accessibility and Adaptation Services	☐
Assisted Living	☐
Personal Emergency Response System (PERS)	☐
Respite	☑

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 Sandards. 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 team's 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 care or similar services for individuals who do not self-direct. These family members can receive compensation for PCA services under very strict guidelines. 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 services, who 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 rescuscitation (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 bur cannot administer the medication to the recipient); reading and recording temperature, pulse, and respiration; observing and documenting the recipient's 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 recipient's living areas in a condition that promotes the recipient's health, comfort, and safety; accompanying the recipient to medically-related appointments or place of employment; providing assistance at the recipient's place of employment; shopping for items to promote the recipient's nutritional status and other health needs; recording and reporting to the supervisory health professional and case manager any changes in the recipient's 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 workers; shall be provided at place of employment, in transit, in residence, and available 7 days per week; shall not be provided in a hospital, nursing facility, intermediate care facility; or institution for mental disease; and when services rendered include two employees from the same agency for different services, 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.

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 under special circumstances and when the relative has the requisite experience.
Specifically, an individual or a family member other than a spouse, parent of a minor child, any other legally responsible relatives, or court-appointed guardian may provide PCA, respite, Chore Aide and Homemaker waiver services. This list does not include parents of adult children, as parents of adult children may provide these services. When these individuals or family members provide waiver services, they must have the same qualifications/experience required for the provider as outlined in the provider qualification section under Appendix C. For other waiver services (i.e. ADHP, PERS, EAA, Assisted Living) the District enrolls provider entities and not professionals directly and does not prohibit payment to waiver participants' relatives who are hired by the entities or does not prohibit a relative's own provider entity from being enrolled as a Medicaid provider. Lastly, the District will allow payments to all relatives who provide OT and PT services. OT and PT services require an initial order by a physician to establish need, so the District will make payments to relatives as long as the relatives have the requisite credentials and licensure required by the District and the Waiver.

○ **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 Office of Provider Services. **There are no time frames for providers to apply to become EPD providers. Once a provider application is submitted for approval, applicants have 30 days to return any requested information. If the information is not returned in 30 days, the application is returned to the provider and the applicant is welcome to reapply at any time in the future.
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. Under the Amendment, Providers have ready access to information regarding requirement and procedures to qualify. This can easily be done by connecting to the Internet and typing www-dc.Medicaid.comThis site maintains all appropriate EPD Waiver providers for enrollment including contact persons.
The Readiness Process begins with a letter from the prospective provider to the EPD Waiver Branch expressing an interest in becoming an EPD Waiver provider. The letter must include:

• 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.

Prospective providers are expected to forward a Letter of Interest as described above to the following address: LTCAprovider@dc.gov .

Within seven (7) business days of the receipt of a letter of interest from a prospective provider, the LTCA will respond to prospective providers via email and assign a tracking number for future reference. The DHCF's LTCA will also provide an overview of the readiness process including a contact person for technical assistance, a checklist of required information and a schedule for attending a mandatory orientation session for prospective providers.

The prospective provider is required to attend an information session coordinated by the LTCA. The meeting 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.

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). Incomplete applications submitted to DHCF will be returned within fifteen (15) days of receipt. 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, including any organizational chart and 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 approval process as a Medicaid-enrolled provider; additional requirements are Quality Improvement Plan, admission process, Code of Conduct, policies and procedures, and agency complaint process.

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.

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 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.

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 drill down to validate that the prospective provider satisfies the requirements described in established criteria. Additionally, complete the Readiness review, listing 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 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 thru 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 timeframe, 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, then the application is denied. If they respond timely and are no deficiencies, then they will be notified of a request to attend 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 an issue a Welcome Letter to the provider.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
Number and percent of new provider applications, by type, who met EPD Waiver qualifications prior to the provision of services N:# of new provider applications who met EPD Waiver qualifications prior to the provision of services D:# of new provider applications

Data Source (Select one):
Other
If 'Other' is selected, specify:
Program Operations Spreadsheet, (DHCF)

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:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of existing providers, by type, who continue to meet EPD Waiver qualifications N# of providers by type who continue to meet the qualifications D:# of existing providers

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 =
☑ **Other** Specify: HRLA	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data	**Frequency of data aggregation and**

aggregation and analysis *(check each that applies):*	**analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
Number and percent of non-licensed/non-certified provider applications, by provider type, that met initial waiver provider qualifications N:# of new non-licensed/non-certified provider applications, by provider type, who met initial waiver provider qualifications D:# Number of non-licensed/ non-certified provider applications

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and persent of non-licensed/non-certified providers, by provider type, who continue to meet waiver provider qualifications N:# of non-licensed/non-certified providers, who continue to meet waiver provider qualifications D:# of all non-licensed/non-certified providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Program Operations Spreadsheet

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(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:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
Number and percent of newly enrolled providers who receive EPD Waiver training within 30 days of enrollment N:# of new providers who receive training in thirty (30) days D:# of new providers

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

that applies):	
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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 takes a plan of corrective action by internally developing and implementing a plan of corrective action when providers do not meet program measures and subsequently administering a deficiency report.

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:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

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, HCB 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 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.

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 this 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 informs 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 ISP.

The Case Manger 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): approves the person's plan of care every six months.

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 ISP, and ensure that the ISP 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 benefciary's home to assist the beneficiary; and the case management ensuring and assisting with placing the beneficiary's name on the list the 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 form 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 statiscally 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 ISP. 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 ISP; 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.

• The case management agency is responsible for monitoring the staff and contractors to ensure the implementation of the ISP and the health and welfare of the beneficiary. DHCF is responsible for monitoring the case management agency to ensure the ISP 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 uses 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 State's quality improvement strategy, provide information in the following fields to detail the State's 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 =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 enrollees chosen at random using automated random selection programs
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and Percent of waiver participants who have service plans that address their health and safety risks N: # of beneficiaries service plans that address health and safety risks D:# of waiver beneficiaries service plans 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 =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 enrollees chosen at random using automated random

		selection programs

☐ **Other**
Specify:

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

Performance Measure:
Number and percent of participants whose ISP was submitted sixty days (60) in advance of the prior authorization expiration date (recertifications) N:# of participants whose ISP was submitted sixty (60) days in advance of the PA expiration date D:# of participants

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 beneficiaries chosen at random using automatic random selection programs (i.e RATSTAT or MMIS Adjunct Software)
	☐ **Other** Specify:	

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**

Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and Percent of participant ISPs that contain the case manager and beneficiary signature indicating authorization. N: # of participant ISPS that contain the case manager and beneficiary signature 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 =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 enrollees chosen at random using automated random selection programs
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's 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:
Number and percent of individuals whose ISP was revised, as needed, to address changing needs. N:# of individuals whose ISP was revised as needed to address changing needs 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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 enrollees chosen at random using automated random selection programs
	☐ **Other** Specify:	

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**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
Number and percent of waiver participants who received services in accordance with the type, scope, amount, frequency and duration specified in the ISP. N:# of waiver participants who received services specified in the ISP D:# of participants reviewed

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 enrollees chosen at random using automated random

		selection programs

☐ **Other**
Specify:

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and 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:
Number and percent of waiver participants whose records contain an appropriately completed and signed freedom of choice form that specifies choice was offered between institutional care and waiver services N:# of participants whose records have a signed freedom of choice form D:# of participants reviewed

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(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:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 enrollees chosen at random using automated random selection programs.
	☐ **Other** Specify:	

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**

☐ **Continuously and Ongoing**	
☐ **Other** Specify:	

Performance Measure:
Number and percent of waiver participants whose records contain an appropriately signed ISP documentation of agreement showing choice of provider and services N:# of waiver participants with signed ISP documentation of agreements indicating choice of providers and services 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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 enrollees chosen at random using automated random selection programs.
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants whose records contain documentation that the beneficiary was afforded choice of providers for each individual waiver service, as opposed to a choice of provider who will deliver all services.

Data Source (Select one):
Medication administration data reports, logs
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:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 enrollees chosen at random using automated random selection programs
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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 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 handles 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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

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 will have the opportunity to: (1) exercise employer authority to recruit, hire, supervise and discharge qualified PDWs who provide PDCS and (2) exercise budget authority to purchase allowable and approved individual-directed goods and services using a PDS budget. Financial Management Services (FMS) and Support Broker services will be 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 and individual-directed goods and services will have access to other traditional services available under the EPD waiver. 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 will have the opportunity to elect to enroll in the Services My Way program and self-direct approved PDCS and individual-directed goods and services.
Current Waiver Participants –
For current waiver participants, when enrollment begins for the Services My Way program, the assigned waiver case manager will inform each waiver participant about the program and the opportunity to self-direct approved PDCS and individual-directed goods and services using standard, easily understandable information approved by DHCF. The process will be repeated each time a waiver participant is reassessed for services and his/her person-centered ISP is updated if he/she is not enrolled in the Services My Way program. All current waiver participants will have the option to enroll in the Services My Way program and develop a new person-centered ISP and a PDS budget that includes PDCS and individual-directed goods and services. 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 will have the participant complete a Consumer Inquiry Form and provide a copy to the Services My Way Program Coordinator. Then, the waiver case manager will review the requirements of the program with the participant, and oversee their signing of the Participant Consent Form. The waiver case manager will also develop, with the waiver participant, a revised person-centered ISP, including the participant-directed service option and a risk mitigation plan using a person-centered approach. He/she will also compute the waiver participant's PDS monthly allocation amount using a standard methodology developed by DHCF. The waiver case manager will send the executed Participant Consent Form along with the waiver participant's revised person-centered ISP, risk mitigation plan and PDS monthly allocation amount to the Services My Way Program Coordinator. The Services My Way Program Coordinator will then forward these documents and a referral for enrollment into the Services My Way program to the VF/EA FMS-Support Broker entity. The VF/EA FMS-Support Broker entity will assign a support broker to the waiver participant and commence the enrollment process.
The PDS budget, developed by the waiver participant and his/her support broker, will be submitted to the Services

My Way Program Coordinator for review and approval. The support broker will conduct a comprehensive orientation and training with the waiver participant/representative-employer using standard, easy to understand materials approved by DHCF. The support broker will also assist the participant/representative employer in completing forms and agreements and providing required information as requested in the Participant/Representative Employer Enrollment Packet and PDW Employment and Individual-Directed Goods and Services Vendor Engagement Packet prepared and distributed by the VF/EA FMS-Support Broker entity and any other forms and/or agreements, as required by DHCF.

New Waiver Participants –

New waiver participants will be 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 will 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, the Medicaid Enrollment Specialist will assist the individual with completing a Consumer Inquiry Form. The form will be submitted to the Services My Way Program Coordinator, who will contact the participant and his/her assigned waiver case manager after the participant is enrolled in the EPD waiver regarding enrollment in the Services My Way program. The participant will then 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 will work with waiver participants enrolled in the Services My Way program to provide support and facilitate their success in self-directing their approved PDCS and individual-directed goods and services and managing their PDS budget. The VF/EA FMS-Support Broker entity will operate in accordance with Section 3504 of the Internal Revenue Code and Rev. Proc. 70-6, as modified by REG-137036-08 and Rev. Proc. 2013-39 and will provide 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 will receive information about using participant-directed services (PDS). As noted above, information regarding PDS will initially be provided to new waiver participants by Medicaid Enrollment Specialists at the ADRC, and to current waiver participants by their waiver case manager. For all waiver participants, the waiver case manager documents the participant's choice of service delivery model in the person-centered ISP. Waiver case managers will also advise participants of their opportunity to change their method of waiver service delivery at any time. Waiver case managers will also re-introduce and provide information about PDS to waiver participants and document the participant's decision as to whether or not to use PDS each time the person-centered ISP is updated if the waiver participant is not already enrolled in the Services My Way program.
With the support of an expert PDS consultant, DHCF has developed materials to inform current and prospective waiver participants about the benefits and potential liabilities of using PDS. Orientation and training materials provided to participants and their 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.
These materials will be distributed to the Medicaid Enrollment Specialists at the ADRC and to all waiver case managers as part of their PDS training, and will be made available on the DHCF and ADRC websites. This information will be shared with all waiver participants upon enrolling in the EPD waiver and during each person-centered ISP update if the participant is not already enrolled in the Services My Way program. This information is written at a level that is easily understood using every day common language to ensure accessibility, and is provided in multiple languages.
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. 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 have one of three (3) types of authorized representatives. These include:
Pre-determined Representative - The participant has a legal guardian or other court appointed representative in place at the time of enrollment and that individual will serve as the designated representative on the individual's behalf.
Voluntary Representative – The participant requests that a representative serve on his/her behalf, or a support broker recommends that the participant designate a representative and the participant agrees. Representatives can include family member, friend or other person who is actively involved in the participant's life, chosen by the participant and who shares authority with the participant for managing the participant's PDS budget. This authority must reflect the desires and preferences of the participant and may include being the common law employer of the participant's PDWs, when appropriate. The participant, with assistance from his/her support broker, as needed, selects his or her authorized representative.
Mandated Representative – A person that the participant, with his/her support broker, chooses and that DHCF requires the participant to have as his or her authorized representative. A mandated representative may be appointed when a participant has misspent funds or his/her function has deteriorated in such a way that the participant is no longer able to manage his/her individual budget. There may be other reasons that cause the DHCF to require the participant to have a mandated representative as a condition of continued participation in the Services My Way program. All types of authorized representatives receive no monetary compensation for being an authorized representative, 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. Accommodations include, but are not limited to, communication devices, interpreters, and physical assistance.
iii. Give due consideration to all information including the recommendations of other interested and involved parties.
iv. Embody the guiding principles of participant direction.
v. Waiver participants and authorized representatives are responsible for working collaboratively to ensure:

1. Waiver participants receive needed PDCS from qualified PDWs, and
2. Services are provided in accordance with the guiding principles of participant direction and in accordance with federal and state Medicaid and program requirements and with the waiver participant's person-centered ISP and PDS budget.

The following safeguards are in place to ensure that the representative is performing in accordance with all of the above requirements: Authorized representatives are required to complete and sign an Authorized Representative Designation Form, which includes, among many others, attestations that the 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 representative is acting in the participant's best interest. Participant-directed workers may also alert the participant's support broker or waiver case manager with any concerns regarding a 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	☑	☑

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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

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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 one, 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 day administrative fee for the VF/EA FMS administrative service provided that is established through the competitive procurement process. The selected vendor must apply the per participant per day fee consistently with each waiver participant/representative employer actively enrolled with the vendor.
The VF/EA FMS-Support Broker entity receives a separate per participant per day 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 day fee consistently with each waiver participant/representative employer 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 waiver participant/representative employer.
The VF/EA FMS-Support Broker entity receives a separate one-time set-up fee for enrolling the PDW in the VF/EA FMS-Support Broker entity's PDW payroll system. The one-time set-up fee is consistent for each qualified 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 will operate in accordance with §3504 of the Internal Revenue Code 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. In addition, the entity will offer 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 to allow for least disruption of services for waiver participants transitioning from traditional PCA waiver services to PDS or back to traditional PCA waiver services;
• 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, information in alternate formats, foreign language translation and ASL, tracking calls and complaints, conducting complaint resolution and satisfaction surveys (paper, web-based, phone)) 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 waiver participant/representative employers with the VF/EA FMS-Support Broker entity;

• Enrolling PDWs in the VF/EA FMS-Support Broker entity's payroll system;
• Processing criminal background checks for PDW candidates and providing results to DHCF, waiver participant/representative employers and PDW candidates;
• 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 person-centered ISP 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;
o Paying workers' compensation insurance premiums on behalf of the participant/representative employer;
o Providing wage information to the workers' compensation insurance carrier to determine workers' compensation insurance benefits, and
o Being the site for the annual workers' compensation insurance audit;
• 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 will monitor and assess the readiness and ongoing performance of the VF/EA FMS-Support Broker entity through a number of monitoring activities. DHCF will conduct a readiness review of the VF/EA FMS-Support Broker entity prior to the contract being finalized and services being implemented. DHCF will also conduct an annual VF/EA FMS-Supports Broker Entity Quality Assessment and Performance Review using the methods described earlier in Appendix A (5) and (6). The VF/EA FMS-Support Broker entity will be required to prepare and submit monthly utilization and expenditure reports to DHCF as required. 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 will conduct a participant/representative employer satisfaction survey within 60 days of the participant enrolling in the Services My Way program, and on an annual basis thereafter. DHCF will analyze the survey results and include them in the VF/EA FMS-Support Broker entity annual performance review.
The VF/EA FMS-Support Broker entity will be required to develop an ongoing Quality Assurance Monitoring Plan, subject to DHCF approval, that includes the following elements:
• Key indicators/measures of quality related to the provision of VF/EA FMS and support broker services;
• A description of how the VF/EA FMS-Support Broker entity plans to monitor these key indicators/measures;

• A description of how the VF/EA FMS-Support Broker entity shall develop, implement, and evaluate corrective actions or modifications to overall operations as necessary to address quality concerns;
• A description of the staffing resources responsible for the quality assurance plan and quality assurance activities;
• Samples of all reports related to quality assurance and performance monitoring, along with descriptions of

their use and who is responsible for reviewing them; and
• A description of how the quality assurance plan shall help DHCF meet all quality assurances as described in its EPD waiver.
• Based on survey results from the Participant/Representative Employer Satisfaction Survey provided by DHCF, the VF/EA FMS-Support Broker entity shall prepare a corrective action plan to address the issues raised as applicable and incorporate issues into its quality assurance process and VF/EA FMS-Support Broker entity's policies, procedures and internal controls, as appropriate.

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 to use PDS or not and the reason for the decision.
• Re-introduces the Services My Way program to waiver participants not enrolled in PDS and documents the participant's decision to use PDS or not and the reason for the decision each time the participant's person-centered ISP is updated using standard outreach and PDS information materials.
• Identifies waiver participants' desired outcomes for using PDS under a person-centered planning process.
• Assists participants who wish to enroll in the Services My Way program to complete a DHCF Consumer Inquiry Form and Participant Consent Form.
• Submits executed DHCF Consumer Inquiry and Participant Consent Forms to the Services My Way Program Coordinator for processing.
• Includes PDS in the participant's person-centered ISP and computes the participant's PDS monthly allocation amount.
• Provides copies of the participant's updated and approved person-centered ISP, risk mitigation plan and PDS monthly allocation amount to the participant and his/her 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.
• Assesses participants' and representatives' receipt of and satisfaction with traditional services.
• Apprises participants of general Medicaid and non-Medicaid rights and responsibilities.

☑ **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

Chore Aide	☐
Participant-Directed Community Support Services	☑
Individual Directed Goods and Services	☑
Case Management	☑
Physical Therapy	☐
Occupational Therapy	☐
Adult Day Health	☐
Personal Care Aide	☐
Homemaker	☐
Environment Accessibility and Adaptation Services	☐
Assisted Living	☐
Personal Emergency Response System (PERS)	☐
Respite	☐

☑ **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 will furnish information and assistance (I&A) supports to waiver participants enrolled in the Services My Way program and their representatives as appropriate. As detailed above, the I&A supports will be procured through a competitive bidding process (RFP) to secure one VF/EA FMS-Support Broker entity, which will serve all waiver participants enrolled in the Services My Way program and their representatives, as appropriate, in the District. Furthermore, as detailed above, the VF/EA FMS-Support Broker entity will receive a consistent per participant per day 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 to waiver participants and their 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 initial skills training 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 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 waiver participant/representative employers in providing the information requested in and 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, if needed and wanted, assessing effectiveness of the authorized representative and selecting a new authorized representative, if necessary.

• Receives waiver participants' PDS monthly allocation amount from the waiver case manager to develop, with the waiver participant and his/her representative, as appropriate, his/her initial PDS budget and any updated budgets.
• Develops, with the waiver participant and his/her representative, as appropriate, the participant's PDS budget for approval from the Services My Way Program Coordinator.
• Updates, with the waiver participant and his/her representative, as appropriate, the waiver participant's PDS budget and submits the budget for approval from 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 from the Services My Way Program Coordinator.
• Assists the participant and his/her representative, as appropriate, in tracking his/her PDS expenditures in accordance with the participant's PDS budget.
• Assists participants and representatives, as appropriate, in identifying and accessing PDS.
• Assists participants and representatives, as appropriate, in making decisions about purchasing individual-directed goods and services.
• Assists participants and 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 individual service plan and PDS budget, their health and safety and to answer questions or concerns.
o The support broker will document their findings in each waiver participant's file at the VF/EA FMS-Support Broker entity.

o A copy of the findings will be provided to the Services My Way Program Coordinator and the participant's waiver case manager.
• Assesses waiver participants' and representatives' use of and satisfaction with PDS through conducting quarterly in-home visits and monthly telephone contacts with participants and representatives.
• Assesses effectiveness of participants' 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.
• Assesses effectiveness of participant's risk mitigation plan related to the receipt of PDS and suggests modifications to the plan, 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 , the VF/EA FMS-Support Broker entity performance is assessed prior to implementation through a readiness review conducted by DHCF. Following implementation of services, 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 supports described above. DHCF also conducts participant/representative employer satisfaction surveys within 60 days of enrollment in the Services My Way program and annually thereafter. The surveys address satisfaction with the I&A services furnished by support brokers as described above.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

E-1: Overview (11 of 13)

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 secure all necessary supports for the waiver participant.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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.

DHCF will develop and implement remediation, training and termination protocol when required for participant/representative-employers who fail to comply with the terms of the Participant/Representative Employer (PRE) Agreement. Non-compliance with the PRE Agreement may be discovered by the VF/EA FMS-Support Broker entity, the waiver participant's support broker, the waiver participant's waiver case manager, or DHCF staff. PREs will be allowed three (3) episodes of non-compliance in the first 12-month period of enrollment in the Services My Way program (and every 12-month period thereafter). The third episode of non-compliance will necessitate the participant's termination from the Services My Way program and a transition to traditional Personal Care Aide (PCA) services. "Traditional" PCA services refer to those PCA services provided by a home health agency. When a common law employer is first found to be out of compliance with the PRE Agreement, the following steps shall occur:
A. The Services My Way Program Coordinator will issue a notification of non-compliance to the PRE (and the assigned Support Broker) regarding the issue of non-compliance, which will:
i. Identify the issue of non-compliance and request that the issue be corrected (if possible), and not repeated.
ii. Detail requirements of the Participant-Directed Corrective Action Plan (PCAP).
iii. Offer training and/or technical assistance.
iv. Encourage the PRE to direct questions to the Support Broker, including the following:
a. To request training or technical assistance, as needed.
b. To request a copy of the PRE Agreement.
c. To ask questions about the notification of non-compliance.
d. To ask questions regarding how to correct the issue of non-compliance.
e. To obtain assistance in preparing and submitting the PCAP.
f. To designate a representative to perform as the PRE (or designate a new representative).
v. Identify consequences of further non-compliance with the PRE Agreement.
vi. Provide details on the participant's fair hearing and appeal rights regarding termination from the Services My Way program, should three (3) episodes of non-compliance occur in the first 12-month period of enrollment in the Services My Way program.
B. The Support Broker will provide copies of the notification to the participant's EPD Waiver Care Manager, the VF/EA FMS-Support Broker entity and other individuals, as necessary and appropriate.
C. Within five (5) business days of issuing the notification of non-compliance, the assigned Support Broker will contact the PRE regarding the occurrence of non-compliance, and cover the following topics:
i. Introductions, reason for the call and reference to the notification of non-compliance.
ii. Identification and review of the issues of non-compliance and a request to have the PRE describe the problem(s) experienced related to the issues of non-compliance.
iii. A request that the issue be corrected (if possible) and not repeated.

iv. Development of the PCAP.
v. Review of the PRE Agreement to answer questions regarding compliance.
vi. Provide an explanation of mandated training and/or technical assistance, which may include:
a. Training and/or technical assistance conducted by the assigned Support Broker,
b. Training and/or technical assistance conducted by the FMS Division of the VF/EA FMS-Support Broker entity in collaboration with the assigned Support Broker.
vii. Identify the consequences should three (3) episodes of non-compliance occur in the first 12-month period of enrollment in the Services My Way program (and every 12-month period thereafter), wherein DHCF may terminate the PRE Agreement with the participant, terminating the participant from the Services My Way program and transition him/her to traditional PCA services.
D. Within five (5) business days of the above mentioned contact, the assigned Support Broker, with the participant and his/her representative, as applicable, will draft a written PCAP based on the conversation and decisions made regarding mandatory training and/or technical assistance, timelines for completion of mandatory training and/or technical assistance, and consequences of not receiving the mandated training and/or technical assistance. The participant and his/her representative, as applicable, must sign the PCAP upon completion. The Support Broker will provide copies of the signed PCAP to the participant's EPD Waiver Care Manager, VF/EA FMS-Support Broker entity and other individuals, as necessary and appropriate.
i. The Support Broker will be responsible for monitoring the PCAP. If the participant or his/her representative, as applicable, fails to implement the PCAP as agreed upon, this will be considered an episode of non-compliance which will be reported by the Support Broker 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 PRE Agreement for a second time, the following steps will occur:
A. The Services My Way Program Coordinator will issue a second notification of non-compliance to the Participant/Representative-Employer (and the assigned Support Broker) regarding the second occurrence of non-compliance, which will:
i. Identify the issue of non-compliance and request that the issue be corrected (if possible), and not repeated.
ii. Detail requirements of the PCAP.
iii. Offer training and/or technical assistance.
iv. Instruct the Participant/Representative-Employer to direct questions to the assigned Support Broker, including the following:
a. To request training or technical assistance, as needed.
b. To request a copy of the PRE Agreement.
c. To ask questions about the notification of non-compliance.
d. To ask questions regarding how to correct the issue of non-compliance.
e. To designate a representative to perform as the PRE (or designate a new representative).
f. To obtain assistance in preparing and submitting the PCAP.
v. Identify consequences of further non-compliance with the PRE Agreement.
vi. Provide details on the participant's fair hearing and appeal rights regarding termination from the Services My Way program, should three episodes of non-compliance occur in the first 12-month period of enrollment in the Services My Way program (and every 12-month period thereafter).
B. DHCF will share a copy of the notification of non-compliance with the assigned Support Broker, who will provide copies of the notification to the participant's EPD Waiver Care Manager, VF/EA FMS-Support Broker entity, and other individuals, as necessary and appropriate.
C. Within five (5) business days of issuing the notification of non-compliance, the assigned Support Broker will contact the PRE regarding the occurrence of non-compliance, and cover the following topics:
i. Introductions, reason for the call and reference to the notification of non-compliance.
ii. Identification and review of the issues of non-compliance and a request to have the PRE describe the problem(s) experienced related to the issues of non-compliance.
iii. A request that the issue be corrected (if possible) and not repeated.
iv. Development of the PCAP.
v. Review of the PRE Agreement to answer questions regarding compliance.
vi. Provide an explanation of mandated training and/or technical assistance, which may include:
a. Training and/or technical assistance conducted by the assigned Support Broker,
b. Training and/or technical assistance conducted by the FMS Division of the VF/EA FMS-Support Broker entity in collaboration with the assigned Support Broker.
vii. Identify the consequences should a third episode of non-compliance occur in the first 12-month period of enrollment in the Services My Way program, wherein DHCF may terminate the PRE Agreement with the participant, terminating the participant from the Services My Way program and transition to traditional PCA services.
D. Within five (5) business days of the above mentioned contact, the assigned Support Broker, with the participant and his/her representative, as applicable, will draft a written PCAP based on the conversation and decisions made

regarding mandatory training and/or technical assistance, timelines for completion of mandatory training and/or technical assistance, and consequences of not receiving the mandated training and/or technical assistance. The participant and his/her representative, as applicable, must sign the PCAP upon completion. The Support Broker will provide copies of the signed PCAP to the participant's EPD Waiver Care Manager, VF/EA FMS-Support Broker entity, and other individuals, as necessary and appropriate.
i. The Support Broker will be responsible for monitoring the PCAP. If the participant or his/her representative, as applicable, fails to implement the PCAP as agreed upon, this will be considered an episode of non-compliance which will be reported by the Support Broker to the Services My Way Program Coordinator.
Third Episode of Non-Compliance: When a PRE is found to be out of compliance with the Participant/Representative-Employer Agreement for a third time, following the participation and completion of mandatory training and/or technical assistance to remediate the issue via successful implementation of the PCAP, the following steps will occur:
A. The Services My Way Program Coordinator will issue a notification of non-compliance to the PRE (and the assigned Support Broker) regarding the third and final episode of non-compliance, which will note that:
i. The PRE has had a third episode of non-compliance.
ii. DHCF is terminating the PRE Agreement with the participant, per earlier notification.
iii. The participant will transition to traditional PCA services.
a. The participant may ask for a fair hearing from the Office of Administrative Hearings or the Office of Health Care Ombudsman. If a request for a fair hearing is filed before termination from the Services My Way program (i.e., within thirty (30) days of the date on the notice), the participant will continue to receive current services while the appeal is pending.
B. The Support Broker will provide copies of the notification to the participant's EPD Waiver Care Manager, the VF/EA FMS-Support Broker entity and other individuals, as necessary and appropriate.
C. Within five (5) business days of issuing the notification of non-compliance, the assigned Support Broker will contact the participant regarding the third and final occurrence of non-compliance, and will cover the following topics:
i. Introductions, reason for the call and reference to the first, second, and third notifications of non-compliance.
ii. Review of consequences of non-compliance (i.e., three (3) episodes in one 12-month period).
iii. Process for transitioning the participant to traditional PCA services with support from the assigned EPD Waiver Care Manager.
iv. Details on the participant's fair hearing and appeal rights regarding termination from the Services My Way program.
D. Within five (5) business days of the above mentioned contact, the Support Broker will initiate completion of the Participant Termination Notice, in accordance with the Participant Termination Notice Instructions.

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		0
Year 2		0
Year 3		0
Year 4		100
Year 5		140

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 participant-directed worker (PDW) will pay for his or her 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 and results will be provided to the PRE and the Services My Way Program Coordinator.

☑ **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.**
☑ **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 will 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 these amendments.

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*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **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 person-centered ISP is developed based on the results of a comprehensive assessment for long term care services and supports using a standard tool. The process for person-centered ISP 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 and his/her support broker by executing the following steps:
(1) The PDS budget contains two (2) cost components: PDCS labor and individual-directed goods and services. (2) The participant will determine the wage rate paid to his/her 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 traditional PCA 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 waiver participants enrolled in the Services My Way program.
The waiver case manager is responsible for explaining the method used to develop the participant's PDS monthly allocation amount and sharing the amount with the participant during the person-centered ISP development process, and with the participant's support broker. Then, the waiver participant works with his/her support broker to determine how the PDS budget will be developed and used to best serve the participant's needs while maintaining his/her health and welfare.
The participant's 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 will be made available to individuals who express an interest in PDS and those who choose to enroll in the Services My Way program through the outreach and training materials provided to them and will be available to the public on the DHCF website.

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 waiver case manager informs the participant of his/her PDS monthly allocation amount during the person-centered ISP development process. After discussing the monthly allocation amount with the participant and his/her representative, as appropriate, the waiver case manager provides the amount to the participant's support broker, who then works with the waiver participant to 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 his/her support broker, may request an adjustment to his/her person-centered ISP and PDS budget by contacting his/her waiver case manager, who will ensure that the participant receives a reassessment. The Services My Way Program Coordinator will notify the participant and his/her support broker of the approval or denial of the request for an adjustment through issuance of a notification letter. If the participant disagrees with the Services My Way Program Coordinator's determination, the participant may request a redetermination of the request. The participant also has the right to the fair hearing and appeals process as outlined in Appendix F.

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 will implement 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 and the entities responsible for implementing these safeguards.
(1) The VF/EA FMS Division will prepare and issue a monthly PDS budget report to PREs and their support brokers, waiver case managers, and the Services My Way Program Coordinator. This report will provide 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 will review this report with the PRE during his/her monthly call and will address any questions.
(2) The VF/EA FMS Division will monitor PDCS utilization by pay period and notify the PRE, his/her support broker, the waiver case manager and the Services My Way Program Coordinator in writing of any overage or underutilization of PDCS. The support broker will then review the situation with the PRE and will address any questions. If there is an overage of PDCS use, the VF/EA FMS Division will collect the amount of the overage from the PRE. An overage of PDCS use will also activate the Participant Remediation, Training and Termination process detailed above, which will require the PRE to prepare a Corrective Action Plan with assistance from his/her support broker that will detail how the PRE will remedy the situation in the future, and the receipt of additional training as needed. The VF/EA FMS Division will identify episodes of significant PDCS underutilization by notifying the PRE, his/her support broker, waiver case manager, and the Services My Way Program Coordinator in writing. The PRE will then address the issue with his/her support broker and develop a Corrective Action Plan as necessary to remedy the situation in the future and receive additional training as needed.

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. DHCF's 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 Ombudsman's 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 24 hours or the next business day, 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 incident's 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 DHCF's, 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 District's 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 DHCF's 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 DHCF's 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 District's steering committee which has responsibility for monitoring performance of all EPD waiver providers.

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 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.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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 instancesof 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:
Number and percent of beneficiaries critical incidents reported by providers within twenty four (24) hours or next business day. N:# of beneficiaries critical incidents reported within 24 hours or next business day; D:# of all critical incidents reported.

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of beneficiaries critical incidents where investigation was initiated within forty-eight (48) hours. N:# of all beneficiaries critical incidents with investigations initiated within 48 hours D:# of all critical incidents investigated.

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☑ **Other** Specify: A random convenience sample of 30 records chosen at random
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of beneficiaries critical incidents where the appropriate follow-up was implemented. N:# of beneficiaries critical incidents where appropriate follow-up was implemented, D:# of all critical incidents reported.

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: A random convenience sample of 30 records chosen at random
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of beneficiaries' complaints investigated within seven (7) days. N:# of beneficiaries complaints investigated within 7 days; D:# of complaints.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CLTC 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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

The percentage of critical incident investigation outcomes notified to the person within 24 hours of closure of the investigation. N= # of critical incident investigation outcomes that were notified to the person and/or their representative within 24 hours of closure of the investigation D # No. of critical incident investigations that were completed/closed.

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenient sample of 30 enrollees chosen at random using automated random selection program
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

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.

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 will use multiple strategies to discover/identify problems/issues using two different complaints storage vehicles:

• A monthly compilation and analysis of complaints uploaded into the case management database system from providers. All providers are required to report information regarding the health and welfare of waiver participants.

• A manually maintained complaints log for concerns received from waiver enrollees and other stakeholders by a) DLTC EPD staff and the b) District of Columbia Health Care Ombudsman (via meetings). This compilation and analysis will be performed by staff in the DLTC EPD.

In addition, annual feedback will be given to the DLTC EPD staff from DHCF's Utilization Management unit based on their annual chart reviews of EPD waiver providers. Finally, Division of Long Term Care's Elders and Persons with Disabilities Branch will conduct monthly on-site reviews of patient care documentation and service delivery.

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 have the opportunity to file incident reports electronically through the District's electronic case management system. Such reports are reviewed by the DLTC Monitoring Unit and the above-referenced actions are initiated.

As potential system improvements, the District also suggests collaborating with HRLA staff who conduct home visits within the EPD Waiver program and working with the DC Long Term Care Ombudsman program to review participant experience and satisfaction.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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 DHCF's 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 DHCF's 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 DHCF's 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. DHCF's 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 DHCF's 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 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:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

Appendix H: Quality Improvement Strategy (1 of 2)

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;
- 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 2)

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 Quality Strategy is as follows. For practices yet to be finalized, specific tasks to be undertaken during the waiver period, major milestones, & identification of the entity responsible for completing tasks are specified.
YEAR ONE: The process used to establish priorities & strategies for, & implement system improvements for year 1 of the waiver are derived from internal State agency review of waiver operational practices; complaints from beneficiaries, the DC Health Care Ombudsman, & external advocacy organizations; & evaluation of the closely related state plan personal care aide (PCA) benefit.
Review of waiver activities by the new Agency management identified priorities for systems improvement: better measurement of system performance; creation of written policies & procedures; reduce delays in waiver application determinations; timely redeterminations, coordination between state plan & waiver PCA services;

& evaluation & remediation of over, under, & mis-utilization of waiver services. Quality improvement (QI) activities under the prior waiver predominantly have occurred on a beneficiary-by-beneficiary, problem-by-problem basis, as opposed to QI activities at the system level.
As a result, priority for the 1st yr of the waiver is to ensure that each waiver assurance is met by:
1 implementing stronger measurement of system performance & follow-up activities for each assurance;
2 writing policies & procedures for waiver activities & training those responsible for implementation;
3 improving waiver application process for beneficiaries;
4 ensuring timely redeterminations;
5 implementing ongoing, valid & reliable processes to measure & remedy over, under, & mis-utilization of waiver services;
6 coordinating PCA service under the waiver with the state plan PCA benefit.
Parties measuring performance & making improvements, & roles & responsibilities are:
Manager, Division of Long Term Care (M, DLT)
1 direct development & documentation of policies & procedures for waiver activities & training those responsible for their implementation;
2 develop & implement approaches to improving the waiver application process;
3 develop & implement an approach to ensure timely redeterminations;
4 develop & implement policies & procedures to coordinate waiver PCA services with the state plan PCA benefit.
Manager, Division of Quality & Health Outcomes (M, DQHO)
develop & implement
1 measurement of delivery system performance, including performance measures for all waiver assurances;
2 ongoing, valid reliable processes to measure & remedy over, under, & mis-utilization of services.
Management Analyst, Division of Quality & Health Outcomes
1 measure delivery system performance using established performance measures & report results to Manager, Division of Long Term Care
2 measure utilization of services to detect over, under, & mis-utilization of waiver services & recommend strategies for remediation.
District of Columbia Long Term Care Coalition
1 reviews measure of delivery system performance & beneficiary experiences with care & suggests strategies for improvement
3 oversees strategies for improving waiver application process, & provides feedback on effectiveness;
4. oversee strategies for ensuring timely redeterminations & provides feedback on effectiveness;
Program Staff, Division of Long Term Care, Elders & Persons with Disabilities Branch
1 implement policies & procedures for waiver implementation;
2 monitor waiver application process; &
3 monitor timeliness of redeterminations.
Tasks to be undertaken during waiver, major milestones for each task, & entity responsible for completing each task are:
TASK 1 Implement stronger measurement of delivery system performance & follow-up activities for each waiver assurance
The District will use the performance measures specified in Appendices A though D to assess compliance with each waiver assurance.. However, additional measures may be needed. Further, the process whereby these measures will be deployed needs to be formalized & embedded into routine operations.
Responsible entity: M, DQHO
Milestones
Review all performance measures specified in the waiver to ensure they adequately & appropriately address all waiver assurances 04/30/2015
Develop new measures & their specifications as needed; 04/30/2015
Develop a table format showing performance measures to be used, entity responsible for calculating the measure according to specifications, the receiver of the performance measure, & the entity responsible for taking follow up action on the measures, as appropriate 04/30/2015
Implement performance measurement & remediation 07/30/2015
Monitor production & use of performance measures to achieve change Begin 07/30/2015 & ongoing.
TASK 2 Write policies & procedures for waiver activities & train those responsible for their implementation
Responsible entity: M, DLT
Milestones
Develop a list of all policies & procedures needed to guide waiver operations & fulfill each assurance. Such policies & procedures will include, but not be limited to: processing applications for waiver participation by elderly persons & persons with disabilities, processing applications from potential providers, prior

authorization of waiver services, conducting monitoring site visits, performing case management responsibilities, achieving timely waiver participation redeterminations, & implementing & maintaining a waiting list for waiver services. 09/30/2015
Write needed policies & procedures 12/3-/11 – 10/30/2015
Obtain Agency sign–off on policies & procedures 12/30/2015
Train responsible staff in policies & procedures 12/30/2015 & ongoing
Implement & monitor waiver activities in accord with policies & procedures 12/30/2015 & ongoing
TASK 3 Improve the waiver application process.
Responsible entity: M, DLT
Milestones This will be undertaken in conjunction with developing policies & procedures for processing applications for waiver participation by elderly persons & persons with disabilities, discussed in TASK 2, above. Work on this is already underway.
Document the current process for processing applications for waiver participation 05/30/2015
Identify recommended approaches to streamline this process & make it more timely & reliable. 06/30/2015
Implement adopted strategies (The date of this milestone is less certain. It will depend on the nature of the action(s) to be adopted. However, we propose the following milestone as a checkpoint: 10/30/2015
Write policies & procedures 10/30/2015
Obtain Agency sign–off on policies & procedures 12/30/2015
Train responsible staff in policies & procedures & implement 12/30/2015 & ongoing
TASK 4 Ensuring timely redeterminations
Responsible entity: M, DLT
Milestones This will be undertaken in conjunction with developing the policies & procedures for waiver eligibility re-determinations in TASK 2, above.
Document the current process for waiver eligibility redeterminations 05/30/2015
Identify recommended approaches to streamline this process & make it more timely & reliable. 06/30/2015
Implement adopted strategies (The date of this milestone is less certain. It will depend on the nature of the action to be adopted. However, we propose the following milestone as a checkpoint): 10/30/2015
Write needed policies & procedures 10/30/2015
Obtain Agency sign–off on policies & procedures 10/30/2015
Train responsible staff in policies & procedures & implement 10/30/2015 & ongoing
TASK 5 Implementing ongoing, valid & reliable processes to measure & remedy over, under, & mis-utilization of waiver services
Creating & implementing ongoing, valid & reliable processes to measure & remedy over, under, & mis-utilization of waiver services is a substantial undertaking that will involve participation & coordination of multiple State Agency Administrative units including the: division of Program Integrity's Surveillance & Utilization Branch, Division of Research Analysis & Rate Setting, Division of Quality & Health Outcomes, & the Health Care Delivery Management Administration's Division of Long Term Care's Elders & Persons with Physical Disabilities Branch.
Responsible entity: M, DQHO
Milestones
Create & convene ad hoc committee (including but not limited to the entities described above) to develop strategy for detecting over, under, & mis-utilization of waiver services: 05/30/2015
Ad hoc committee develops comprehensive, coordinated monitoring plan. The Monitoring Plan will identify data to be collected & analyzed, sources of the data, entities responsible for collecting & analyzing the data to generate reliable & valid information on utilization, frequency of data collection & analysis, & the entities responsible for taking remedial action as needed. 05/30/2015
Implementation of processes for detection & remediation of over, under, & mis-utilization: 08/30/2015 & ongoing.
TASK 6 Coordinate PCA services under the waiver with state plan PCA benefit.
Both the state plan & this waiver offer personal care aide (PCA) services. Analysis of these benefits by the new management team has detected that this can sometimes result in two different agencies delivering personal care aide services, separate prior authorization requests by the two different agencies, & care plans that are not always coordinated. Further, the state plan benefit has recently implemented a number of reforms to ensure more appropriate use & higher quality of PCA services, & more are planned for FY12. The delivery of PCA waiver services will be improved by the coordination of these two benefits & delivery reform initiatives.
Responsible entity: M, DLT
Milestones:
Analysis of the array of potential reforms to better coordinate state plan & waiver PCA benefits. Potential reforms include but are not limited to: 1) when a waiver enrollee is receiving PCA services both through the

waiver & the state plan, require that the PCA provider be one & the same for both state plan & waiver services; 2) implement as improved waiver processes the use of the new Physician order form, assessment instrument & care plan forms recently adopted for the state plan PCA benefit; 3) use a separate entity to perform assessment & care plan development to avoid potential conflicts of interest that might occur when the entity developing the care plan is the entity that will be delivering the services. 1/30/12
From the analysis, identify the specific reforms to be implemented 2/15/12
Complete a work plan for implementing the identified reforms, including the production of any needed regulatory changes or modifications of the waiver. 3/15/12.
Adoption of all items contained in the work plan – Timelines will vary according to each reform item.
TASK 7 Develop & Implement Continuous Quality Improvement Strategy (CQIS) for Waiver Year 2 & beyond.
The above tasks will occur in Waiver Year 1 & will address changes already identified by the team responsible for successful waiver implementation. Beyond these immediate issues to be addressed in the current waiver year, a CQIS for Waiver Yrs 2 & beyond will be developed & implemented.
Responsible entity: M, DQHO
Milestones
Create & convene ad hoc committee to develop CQIS beginning in years 2 & beyond: 08/30/2015
Monthly meetings of ad hoc committee to develop ongoing plan specifying: how participants, advocates, & others will participate in the CQIS; processes to assess effectiveness of the waiver & system improvements; measures & processes employed for remediation; how areas for improvement will be identified & prioritized; processes & timelines for compiling information & communicating to external parties; & processes to assess & revise QIS as needed. 08/30/2015
Train parties responsible for implementing the CQIS 08/30/2015 - 10/30/2015
Implementation of the CQIS for yrs 2 & beyond 08/30/2015

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **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.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Appendix H: Quality Improvement Strategy

The Quality Improvement Strategy is not fully developed at this time. Below is the work plan DHCF will follow to fully develop the Quality Improvement Strategy, including: specific tasks to be undertaken during the waiver period, major milestones associated with each task, and identification of the entity responsible or completing the tasks.

Task 1. Convene and charge DHCF Team responsible for Quality Improvement Activities. DHCF underwent a second realignment in June of 2011 (the first occurred in October of 2010), which, among other things, moved the former Office of Quality Management into the Health Care Delivery Management Administration, in which the Division of Long Term Care and its Elders and Persons with Disabilities Branch (EPDB) are located. This move was undertaken to more closely integrate quality improvement activities and a focus on health outcomes into the delivery of Medicaid services.

Simultaneous with this realignment, new recruitment activities were undertaken for key management positions responsible for this waiver. As a result, a new Director of HCDMA was hired, a new Manager of the Division of Long Term Care has been hired, and recruitment of a new manager for the EPDB is underway. Al l of this has transpired in the last four months.

The new Manager of the Division of Long Term Care is in the midst of an assessment of responsibilities and work activities of all staff in the EPDB. She has determined that the vast majority (approximately 90%) of activities are problem-solving interventions on a beneficiary by beneficiary, problem by problem basis. Little to no measurement of delivery system performance, beneficiary experiences with care, or health status has occurred.

In the next three months, prior to the renewal of this waiver, the Manager, DLTC will complete her evaluation of staff function and assign responsibilities for systems assessment activities and quality improvement activities for each of the six assurances contained in the waiver. This will be done in collaboration with and using the personnel resources of the Division of Quality and Health Outcomes (Formerly the Office of Quality Management). The Division of Quality and Health Outcomes has assigned one staff person to work exclusively with the Division of Long Term Care on Quality Measurement and Improvement Activities.

Although this strategy is not completely in place, it will be completed by June 2015. The completion of these task will be directed by DHCF''s Director of Long Term Care Administration and Manager of the Division of Quality and Health Outcomes, who together have substantial experience and expertise in health care quality measurement and improvement in general, and for the Medicaid program, in particular.

Task 2 Identification of desired structural features, operational processes and beneficiary outcomes for each of the following waiver assurances: evaluation of need, choice of alternatives, health and welfare, financial assurances, reporting, and expenditures, and for the participant directed services option of the waiver.

Because the design of this proposed waiver is nearly identical to that of DHCF's current waiver, DHCF staff has already identified key systems issues in which quality can be improved. These include, for example: the length of time it takes an applicant to be enrolled in the waiver (when the waiver cap has not been reached), reliability of care planning processes, coordination of the waiver service with state plan services, incorporation and encouragement of provision of care by informal supports (avoiding "crowd out"), provider knowledge of their responsibilities for case management, and case management itself. Although the few areas identified above are readily identified by staff as areas in need of improvement, DHCF will conduct its own comprehensive assessment of structural and operation safeguards and desired beneficiary outcomes that will serve as goals for the new waiver. This will be conducted through key informant interviews with

DHCF staff, beneficiaries, advocates and waiver providers. For each of these performance standards, performance measures will need to be developed.

Task 3. Develop detailed specifications for measures of waiver performance for each performance standards. Too often, performance measures are unreliable indicators of quality because the specifications for calculating the measure lack validity and reliability. Once the quality standards are identified, the data sources for calculating the measures, the means of collecting the data, the specifications to be followed in calculating the measure, will need to be documented. The parties responsible for each of these activities will also be determined, as well as the frequency for the data collection.

Task 4. Develop process for feeding back measurement results to parties responsible for meeting the standard and identify incentives to be used to stimulate improvement. Measurement is necessary, but not sufficient for improving quality. Although the science of quality improvement has not yet shown how to guarantee improvement, certain activities have played a part in multiple quality improvement initiatives. These include: the engagement of a credible and influential leader in quality improvement (a "Champion" for quality improvement), feeding back measurement results to providers and sharing where a provider compares against its peers, publishing performance via a "report card" and use of financial incentives to reward goal attainment or significant improvement. Over the next six months, DHCF will determine which of these (or other) approaches it will use to stimulate quality improvement. It is likely that diverse and multiple incentives may need be planned to be used for different assurances.

Billing and Claims:
HCOA will review the Quality Improvement Strategy (QIS) as part of its weekly management meeting to identify areas that require system changes. Those changes will be defined and formal CSRs will be created for each required change. The CSRs will follow the current system's change process described in section H.1.a.i. As the QIS evolves, HCOA will review any updates to assess the impact to the system. As system changes are completed HCOA will update the QIS to reflect the progress made.

With respect to remediation activities, the following general system is in place:
As part of their responsibilities as the District's Fiscal Agent, ACS maintains systems staff that are responsible for the development and maintenance of financial reports. These reports include both federally mandated reports and proprietary reports as requested by the Office of the Chief Financial Officer (OCFO). If there are any suspected issues with any aspect of financial reporting, the OCFO and ACS staffs meet to discuss the issue and identify solutions. As a general part of root cause analysis, ad hoc reports are generated and reviewed. Any issues related to financial reporting are considered open until approval is obtained from the OCFO. If a system change or change to a production report is required to remedy an issue, the formal CSR process is adhered to. If the issue is resolved, absent the need for a CSR, emails are exchanged documenting any formal decisions made and capturing any data used to come to those decisions.

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.

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. These audits consist of visits to waiver providers' offices to 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. 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.

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 FFY 2010, KPMG conducted the Single Audit.

4236 AUDITS AND REVIEWS

4236.1 The MAA shall perform ongoing audits to ensure that the provider's services for which Medicaid payments are made are consistent with efficiency, economy, quality of care, and made in accordance with federal and District rules governing Medicaid.

4236.2 The audit process shall be routinely conducted by MAA to determine, by statistically valid scientific sampling, the appropriateness of services rendered and billed to Medicaid and that services were only rendered to Medicaid-eligible individuals.

4236.3 Each provider of waiver services shall allow access, during an on-site audit or review (announced or unannounced) by MAA, other District of Columbia government officials, and representatives of the United States Department of Health and Human Services, to relevant records and program documentation.

4236.4 The failure of a provider to timely release or to grant access to program documents and records to the MAA auditors, after reasonable notice by MAA to the provider to produce the same, shall constitute grounds to terminate the provider agreement.

4236.5 If MAA denies a claim, MAA shall recoup, by the most expeditious means available, those monies erroneously paid to the provider for denied claims, following the period of Administrative Review set forth in § 4237.5 of this chapter.

4236.6 The recoupment amounts for denied claims shall be determined by the following formula: A fraction will be calculated with the numerator consisting of the number of denied paid claims resulting from the audited sample. The denominator shall be the total number of paid claims from the audit sample. This fraction will be multiplied by the total dollars paid by MAA to the provider during the audit period to determine the amount 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.

4236.7 The MAA shall issue a Notice of Recoupment (NR), 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.

SOURCE: Final Rulemaking published at 50 DCR 9025 (October 24, 2003).

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(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:
Number and percent of waiver service claims reviewed that were submitted for participants who were enrolled in the waiver on the date that the service was delivered. N:# of waiver service claims reviewed D:# of waiver service claims submitted.

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

☑ **Continuously and Ongoing**	☐ **Other** Specify:
☐ **Other** Specify:	

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**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver claims reviewed that were paid using the correct rate as specified in the waiver application. N:# of waiver claims reviewed using the correct rate, D:# of waiver claims reviewed.

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Convenience sample of 30 claims chosen at random using automated random selection program (e.g., RATSTAT or MMIS-adjunct software).
	☐ **Other** Specify:	

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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

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 opportunites for review, analysis, detection, and refinement.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
Problems related to financial accountability are addressed in three ways: by focusing on the MMIS and creating payment rule edits, by focusing on providers, and by focusing on program integrity as part of provider post payment audits and reviews. All these methods can and often do occur concurrently with appropriate communication among all parties involved as independent units within the agency
.
The first method is to focus on MMIS payment rules:
As part of its responsibilities, the District's fiscal agent maintains systems staff and contractors who develop, maintenance, and produce automated financial reports. The reports include both federally mandated reports (including the 372 waiver reports) and specialized financial oversight reports requested by the Office of the Chief Financial Officer (OCFO). If there are any suspected issues with any aspect of financial reporting, the OCFO, waiver program staff, and the fiscal intermediary meets to discuss the issues and identify solutions. In addition, as a general part of root cause analysis, ad hoc reports are frequently generated and reviewed. Any issues related to financial reporting and this waiver are considered "open" until approval is obtained from the OCFO. If a system change or change to a production report is required to remedy an issue, the formal process for requesting changes to the MMIS system is adhered to. When the issue is resolved, emails are exchanged documenting formal decisions made and capturing any data used to come to those decisions.

The second method focuses on provider remediation, which includes:
1. Meeting with providers (individually or as a group) to deliver education to correct the detected problems. This will often be used for a first time occurrence of a problem of a specific type. Meetings will be conducted by staff from DHCF's 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 is made by DHCF's 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 are addressed through additional training and the delivery of a written notice from DHCF requiring the correction of the problem. DHCF's Elders and Persons with Physical Disabilities Branch is also responsible for written communication with individual providers and retains documentation of such.
The third method relies on DHCF's Office of Program Integrity (OPI) Surveillance and Utilization Review Branch (SUR) Audits and Reviews:
DHCF's Surveillance and Utilization Review Branch monitors utilization, including appropriateness of health care services, to ensure that appropriate care is provided to publicly funded enrollees; to identify and investigate suspected abuse by both enrollees and providers in the publicly funded programs; and to ensure that DHCF funds are appropriately utilized.

SUR reviews providers' patterns of care delivery and billing, undertakes corrective actions when needed, and educates providers on relevant laws, regulations, and other program requirements.

1. A Compliance audit is a comprehensive review of an organization's adherence to contractual and regulatory

guidelines to evaluate the strength and thoroughness of its compliance preparations. Auditors review polices & procedures, internal controls and risk management procedures over the course of an audit.
2. A Claims Billing audit is a review of medical records and other relevant documents to determine whether the documentation supports payment of a claim for services.
3. Problems that persist are addressed through more stringent means including the recoupment of Medicaid payment associated with claims related to the service plan problem. Such recoupments are handled by DHCF's Surveillance and Utilization Review Branch (SUR).
OPI is also responsible for preventing, detecting and eliminating fraud, abuse and waste by persons who provide and receive waiver services; and for improving the reliability and efficiency of DHCF internal processes. OPI identifies and addresses fraud and intentional misuse of Medicaid resources; and how DHCF internal processes can be strengthened to improve the delivery of high quality health care.

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:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In [illegible] 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).

The following principles apply to provider payment rate development for waiver services: Provider payment rates are uniform for every provider; DHCF, the Medicaid Agency for the District of Columbia, elicits public comments

through the District rule-making process, which provides a 30 day public comment period, and Information regarding payment rates are available to waiver participants via publication of the proposed and ratified rules, which is publicly available. DHCF is responsible for all rate development with assistance of staff from LTCA/EPD Branch and the Office of Rates, Reimbursement and Financial Analysis (ORRFA). Together, these units develop rates for each EPD waiver service. Rate information is available to Medicaid participants and community members upon request and on DHCF website at http://dhcf.dc.gov. Transmittals are sent to providers indicating modification in rates and rate structure. The rate process includes market analysis, review of rate structure and methodology in surrounding jurisdictions. Meetings are held with providers, community stakeholders, DC Council and Long Term Care Coalition to assess outstanding issues and community needs, discuss rates and rate structure as rates for direct care workers (Personal Care Aide (PCA) and Home Health Aide (HHA) and review assessment of expertise and capacity of providers and services.

The aforementioned rate structures are determined based on a geographic market analysis. Each service is reviewed and compared to providers offering services in surrounding jurisdictions. There is no automatic inflation increase. In January 2006 direct care worker rates, (not nursing) were adjusted to provide a realistic rate in line with neighboring jurisdictions and consistent with DC Council mandate to provide a rate more acceptable for direct care workers (a living wage rate). The change in rate was designed to stabilize the pool of workers. Personal care aides reimbursement methodology was updated (see below). The rate setting methodology used for Medicaid services delivered through the traditional agency-based model will remain the same for those services that are participant-directed. Participants who elect to use PDS will determine the hourly rate paid to their participant-directed workers within the range set by DHCF, which falls between the District's established living wage and the rate paid to personal care aides delivering Waiver services through the agency-based model. The Vendor F/EAFMS-Support Broker entity will assist participants who elect to use PDS through the provision of financial management and support broker services, and will receive a per-member-per-day payment for the provision of these services. In addition to the per-member-per-day payment, the Vendor F/EA FMS-Support Broker entity will receive a one-time payment for enrolling each 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 the Vendor F/EA FMS-Support Broker entity will be determined after the competitive bidding process for the Vendor F/EA Support Broker entity contract is complete. The method for excluding the cost of room and board furnished in residential settings is as follows: Service rate for Assisted Living was based upon a geographic market analysis and meetings with Assisted Living Service Providers, large, medium and small and meetings with advocates, community leaders, national and local experts, like Robert L. Mollica, Senior Program Director for National Academy of State Health Policy. The TAG Group and DHCF examined average daily rate for all inclusive costs among the small and medium sized Group Homes that were considering taking on Medicaid Assisted Living participant. The TAG asked for a review of current costs among the small group home providers for services that they were providing or believed were needed. We asked for information on reasonable and customary services and how much did they pay for those services and how often were they used, daily and weekly. The weekly costs were then multiplied by fifty two weeks, divided by number of persons receiving those services. This number was shared with the TAG who then reviewed their figures against those developed by DHCF. It was explained to the TAG group that Medicaid would not pay for Room or Board, only health care related services. The percentage of room and board costs were between 50 and 60 percent of total Assisted Living expenditures. This percentage was subtracted from overall rate leaving costs that were on average $22,000 annually. This $22,000 cost was divided by 365, average cost of $60 a day. The $22,000 was compared to several facilities and was less than half expensive as other Assisted Living facilities in the region. There was no automatic inflation increase and there is no set methodology for determining rate increases. Assisted Living rates will be adjusted periodically.

1) Reimbursement rate for assisted living services shall be sixty dollars ($60.00) per day.

2) The rate is all-inclusive rate for all services provided. Providers shall not bill for individual services.

A. By adding section 4239 (Specific Provider Requirements: Assisted Living Services) to read as follows: Each facility providing assisted living services shall be licensed by the District of Columbia and comply with the requirements set forth in the Assisted Living Residence Regulatory Act of 2000, effective June 24, 2000 (D.C. Law 13-127; D.C. Official Code § 44-101.01 et seq.) and attendant rules, and meet all other District regulatory requirements. Assisted living services may consist of any combination of the Services which meet the resident's needs as outlined in the written individualized service plan. Services may include the following: (a) PCA; (b) Chore Aide; (c) Therapeutic social and recreational services.

The new case management methodology under the EPD Waiver is as follows: 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 approach provides a better correlation between reimbursements and the number of beneficiaries receiving case management services. The methodology used for establishing the capitation rate includes: A reasonable cost/ average industry salary for typical case managers. In determining the reasonable salary, DHCF relied on the most 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 now called "Service Coordinators"

with job functions generally classified in grade 11. While the 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 each case manager at DDS crosses a large span of cases, and it 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 the 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).
The new Chore Aide and Homemaker methodology under the EPD Waiver is as follows: 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. Home Health Agencies employ homemakers or chore aid workers, who support individuals through heavy cleaning, meal preparation, bathing, and housekeeping. Personnel are assigned according to the needs and wishes of each client. Prior authorization (PA) is required to provide those services. DHCF reimbursed Home Health Agency for both Chore Aide and Homemaker services under the EPD Waiver. Chore Aide professionals are currently reimbursed at 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 the reimbursement rates for both Chore Aide and Homemaker services to reimburse providers at rates that cover necessary employment related taxes, benefits and other administrative overhead costs. The reimbursement methodology was established as follows: The reimbursement rate is calculated using the living wage of $13.80 as the base, with an addition of 30% for employee related taxes, benefits and overhead costs.
Computation
• 1. Base Rate (Living Wage) = $13.80 + $4.14 (30%)
• FY 2016 Rate – October 1, 2015 $17.94 x 2.3% (CPI) = $18.35

The rate will be inflated annually beginning with FY 2016, by any adjustment to the living wage and inflation based on the Centers for Medicare and Medical Services (CMS) Skilled Nursing Facility Market Basket Index.
The EPD Waiver Amendment is adding three new services:
1) Physical Therapy
2) Occupational Therapy
3) Adult Day Health.
Home Care Agencies (HCA) can now provide OT and PT services, as well as independent OT and PT practitioners services will be covered under the EPD Waiver program.
Reimbursement Methodology
Each provider shall be reimbursed at the current reimbursement rate for OT and PT under the current State Plan reimbursement methodology and rates.
ADHP is a new service under the EPD Waiver Program. To be reimbursed for ADHP services under the EPD Waiver program, providers are required to meet the same qualifications and licensing requirements for the ADHP covered in the State Plan.
Each provider 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. Acuity Level 2 represents the health and support needs of a beneficiary whose needs based assessment reflects a score of 6 or higher.
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.
The following change was made during the District's August 2015 Informal Request for Information questions-
DHCF updated the reimbursement rates for Personal Care Aide (PCA) based on an audit of Home Health Agency (HHA) cost reports. The new rate covers the DC Living Wage increases, employment related taxes, employee benefits and a reasonable administrative overhead costs. The reimbursement methodology was established based on the following components;
• District's living wage of $13.80 as established by the DC Department of Employment Services
• 10.83% Taxes – Social Security (6.2%), Medicare (1.45%), Workers Compensation (2%) and Unemployment Benefits (1.18%)
• 7.4% Employee Benefits – Medical Insurance and Sick Leave Provision
• 18% - Provider Indirect Administrative Overhead based on reasonable comparisons with other comparable provider categories.
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.

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. *Select one:*

- (●) **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.**

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*:

- [x] **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:

Assisted Living is a service of the Elderly and Persons with Physical Disabilities Waiver.
The service rate for Assisted Living was based upon a geographic market analysis that included a Technical Assistance Group and meetings with a cross section of Assisted Living Service Providers, large, medium and small and meetings with advocates, community leaders, national and local experts, including dialogue with Robert L. Mollica, Senior Program Director for the National Academy of State Health Policy. These meetings led to recommendations based on costs and review of service providers across the District of Columbia, Suburban Maryland and Northern Virginia. The TAG Group and DHCF examined the average daily rate for all inclusive costs among the small and medium sized Group Homes that might be interested in providing Assisted Living for District Medicaid residents either because they were already taking care of SSI and SSA participant or Nursing Facilities or other facilities that were considering taking on Medicaid Assisted Living participant. The TAG asked for a review of current costs among the small group home providers for services that they were providing or believed were needed. We asked for information on what were reasonable and customary services and how much did they pay for those services and how often were they used or offered, daily and weekly. The average weekly costs were then multiplied by fifty two weeks and then divided by number of persons receiving those services. This number was shared with the TAG who then reviewed their figures against those developed by DHCF. It was explained to the TAG group that Medicaid would not pay for Room or Board, only health care related services. The percentage of room and board costs were between 50 and 60 percent of total Assisted Living expenditures. This percentage was subtracted from the overall rate leaving costs that were on average $22,000 annually. This $22,000 cost was then divided by 365 days leaving an average cost of $60 a day. The $22,000 was compared to several facilities and was less than half as expensive as other Assisted Living facilities in the region. This was compared to the estimated number of persons that might be interested in Assisted Living and to geographic differences and provider supply. There was no automatic inflation increase and there is no set methodology for determining rate increases. It is anticipated that Assisted Living rates will be adjusted periodically to ensure adequate provider supply.

4238.1 The reimbursement rate for assisted living services shall be sixty dollars ($60.00) per day.

4238.2 The rate is an all-inclusive rate for all services provided. A provider shall not bill for individual services.

A. By adding section 4239 (Specific Provider Requirements: Assisted Living Services) to read as follows:

4239 SPECIFIC PROVIDER REQUIREMENTS: ASSISTED LIVING SERVICES

4239.1 Each facility providing assisted living services shall be licensed by the District of Columbia and comply with the requirements set forth in the Assisted Living Residence Regulatory Act of 2000, effective June 24, 2000 (D.C. Law 13-127; D.C. Official Code § 44-101.01 et seq.) and attendant rules.

4239.2 Each assisted living residence shall support the resident's dignity, privacy, independence, individuality, freedom of choice, decision making, spirituality and involvement of family and friends.
Providers may not bill for room or board or non-therapeutic health related services not identified in 4240.1.

4240.1 Assisted living services may consist of any combination of the
Services which meet the resident's needs as outlined in the written individualized service plan required pursuant to section 4202 of the District's EPD rules. Services may include the following:

(a) Personal care aide services;
(b) Chore Aide;
(c) Therapeutic social and recreational services

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	23160.56	22118.91	45279.47	67643.27	61615.21	129258.48	83979.01
2	21325.92	20316.97	41642.89	72120.36	9294.76	81415.12	39772.23
3	19764.93	18515.03	38279.96	76597.45	10195.76	86793.21	48513.25
4	10925.43	16713.09	27638.52	81074.53	10671.98	91746.51	64107.99
5	15859.08	14911.15	30770.23	85551.62	11148.21	96699.83	65929.60

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	4660	4660
Year 2	4760	4760
Year 3	4860	4860
Year 4	4960	4960
Year 5	5060	5060

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 in the District's EPD Waiver has been reported in the CMS 372 report. The historical information indicated that the EPD Waiver continues to grow but has been impacted by participant turnover. This turnover has occurred in the District most often when a person dies, or is institutionalized (Nursing Home) or in a few cases participants have moved out of the area, (most often to live with a relative). The District derived this information looking over the past five years through November 2009. The District took the total number of enrolled days divided by total number of participants.

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 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. The 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.

• Total Unduplicated Participants for future waiver years 1-5 increases by weighted average annual growth rate based on population growth
• Even though three quarters of future year 1 is in FY 2012, which is capped at 3,940, assumption is there will be a waiting list and that the final quarter will quickly allow new enrollees up to the growth rate immediately
• Total Days of Waiver Coverage for future waiver years 1 – 5 increases per the trend history of actual waiver year data for years 1 – 4, capping at the maximum days per year
• Factor D' for future waiver years 1 – 5 increases per the trend history of actual waiver year data for years 2 - 4 (year 1 was a high ramp-up year and is not considered)
• Factor G and Factor G' for future waiver years 1 – 5 increases per the trend history of actual waiver year data for years 1 - 4

Census 2000 data and which incorporate a number of other data sources to estimate the change effects of interstate migration, births and deaths. The 2010 Census figure published for the District's total population was used as the basis for later years' projections. National rates of change among the population as a whole, and for the two age groups, were calculated from Census projection estimates and applied to the estimated 2010 District population.

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' calculates the annual average per person cost for all other services (non-waiver specific) for individuals in the EPD waiver program. To project this factor for the current waiver period year 5 and future waiver period years 1-5, we forecasted each year by trending off the historical Factor D' data for the current waiver period years 2-4. The current waiver period year 1 was not included in the trending as it was considered a high outlier in the ramp of year of the first year for the waiver program.

District population estimates were derived from published 2009 Census estimates, which are based initially on Census 2000 data and which incorporate a number of other data sources to estimate the change effects of interstate migration, births and deaths. The 2010 Census figure published for the District's total population was used as the basis for later years' projections. National rates of change among the population as a whole, and for the two age groups, were calculated from Census projection estimates and applied to the estimated 2010 District population.

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 and Factor G' for future waiver years 1 – 5 increases per the trend history of actual waiver year data for years 1 – 4.

District population estimates were derived from published 2009 Census estimates, which are based initially on Census 2000 data and which incorporate a number of other data sources to estimate the change effects of interstate migration, births and deaths. The 2010 Census figure published for the District's total population was used as the basis for later years' projections. National rates of change among the population as a whole, and for the two age groups, were calculated from Census projection estimates and applied to the estimated 2010 District population.

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 and Factor G' for future waiver years 1 – 5 increase per the trend history of actual waiver year data for years 1 - 4

District population estimates were derived from published 2009 Census estimates, which are based initially on Census 2000 data and which incorporate a number of other data sources to estimate the change effects of

interstate migration, births and deaths. The 2010 Census figure published for the District's total population was used as the basis for later years' projections. National rates of change among the population as a whole, and for the two age groups, were calculated from Census projection estimates and applied to the estimated 2010 District population.

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
Personal Care Aide
Respite
Assisted Living
Chore Aide
Environment Accessibility and Adaptation Services
Individual Directed Goods and Services
Occupational Therapy
Participant-Directed Community Support Services
Personal Emergency Response System (PERS)
Physical Therapy

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:						**0.00**
Adult Day Health	daily	0	0.00	0.01	**0.00**	
Case Management Total:						**4749059.52**
Case Management Initial Assessment	initial assessment	110	1.20	310.11	**40934.52**	
Case Management Visit	visit	4050	7.50	125.00	**3796875.00**	
Case Management Annual Reassessment	reassessment	4050	1.00	225.00	**911250.00**	
Case management per						

member per month	month	0	0.00	0.01	**0.00**	
Homemaker Total:						**1014369.30**
Homemaker	hourly	59	1637.40	10.50	**1014369.30**	
Personal Care Aide Total:						**100180628.04**
Personal Care Aide	15 minutes	3749	6549.50	4.08	**100180628.04**	
Respite Total:						**189358.18**
Respite 1-17 hours/day	15 minutes	84	549.10	4.08	**188187.55**	
Respite 18-24 hours/day	day	4	27.30	10.72	**1170.62**	
Assisted Living Total:						**963600.00**
Assisted Living	day	44	365.00	60.00	**963600.00**	
Chore Aide Total:						**9120.00**
Chore Aide	hourly	19	32.00	15.00	**9120.00**	
Environment Accessibility and Adaptation Services Total:						**25000.00**
Environment Accessibility and Adaptation Services	assessed	5	1.00	5000.00	**25000.00**	
Individual Directed Goods and Services Total:						**0.00**
Individual Directed Goods and Services	annual	0	1.00	500.00	**0.00**	
Occupational Therapy Total:						**0.00**
Occupational Therapy	15 minutes	0	0.00	0.01	**0.00**	
Participant-Directed Community Support Services Total:						**0.00**
Participant-Directed Community Support Services	15 minutes	0	0.00	4.08	**0.00**	
Personal Emergency Response System (PERS) Total:						**797060.00**
Personal Emergency Response System Installation	flat rate	518	1.00	40.00	**20720.00**	
Personal Emergency Response System Rental	month	2270	12.00	28.50	**776340.00**	
Physical Therapy Total:						**0.00**
Physical Therapy	15 minutes	0	0.00	0.01	**0.00**	
				GRAND TOTAL:		**107928195.04**
				Total Estimated Unduplicated Participants:		**4660**
				Factor D (Divide total by number of participants):		**23160.56**
				Average Length of Stay on the Waiver:		323

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:						**0.00**
Adult Day Health	daily	0	0.00	0.01	**0.00**	
Case Management Total:						**4880350.15**
Case Management Initial Assessment	initial assessment	113	1.20	309.92	**42025.15**	
Case Management Visit	visit	4162	7.50	125.00	**3901875.00**	
Case Management Annual Reassessment	reassessment	4162	1.00	225.00	**936450.00**	
Case management per member per month	month	0	0.00	0.01	**0.00**	
Homemaker Total:						**1375416.00**
Homemaker	hourly	80	1637.40	10.50	**1375416.00**	
Personal Care Aide Total:						**92784776.54**
Personal Care Aide	15 minutes	3858	5894.60	4.08	**92784776.54**	
Respite Total:						**223886.10**
Respite 1-17 hours/day	15 minutes	87	627.10	4.08	**222595.42**	
Respite 18-24 hours/day	day	4	30.10	10.72	**1290.69**	
Assisted Living Total:						**1182600.00**
Assisted Living	day	54	365.00	60.00	**1182600.00**	
Chore Aide Total:						**9600.00**
Chore Aide	hourly	20	32.00	15.00	**9600.00**	
Environment Accessibility and Adaptation Services Total:						**25000.00**
Environment Accessibility and Adaptation Services	assessed	5	1.00	5000.00	**25000.00**	
Individual Directed Goods and Services Total:						**5000.00**
Individual Directed Goods and Services	annual	10	1.00	500.00	**5000.00**	
Occupational Therapy Total:						**0.00**

Occupational Therapy	15 minutes	0	0.00	0.01	**0.00**	
Participant-Directed Community Support Services Total:						**43656.00**
Participant-Directed Community Support Services	15 minutes	10	1070.00	4.08	**43656.00**	
Personal Emergency Response System (PERS) Total:						**981092.00**
Personal Emergency Response System Installation	flat rate	536	1.00	40.00	**21440.00**	
Personal Emergency Response System Rental	month	2806	12.00	28.50	**959652.00**	
Physical Therapy Total:						**0.00**
Physical Therapy	15 minutes	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**101511376.80**
Total Estimated Unduplicated Participants:	**4760**
Factor D (Divide total by number of participants):	**21325.92**
Average Length of Stay on the Waiver:	365

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:						**0.00**
Adult Day Health	daily	0	0.00	0.01	**0.00**	
Case Management Total:						**5276477.52**
Case Management Initial Assessment	initial assessment	116	1.00	309.72	**35927.52**	
Case Management Visit	visit	4278	8.00	125.00	**4278000.00**	
Case Management Annual Reassessment	reassessment	4278	1.00	225.00	**962550.00**	
Case management per member per month	month	0	0.00	0.01	**0.00**	
Homemaker Total:						**1426994.10**
Homemaker	hourly	83	1637.40	10.50	**1426994.10**	
Personal Care Aide Total:						**86384428.73**
Personal Care Aide	15 minutes	3991	5305.10	4.08	**86384428.73**	

Respite Total:						**264879.20**
Respite 1-17 hours/day	15 minutes	90	705.00	4.08	**258876.00**	
Respite 18-24 hours/day	day	5	112.00	10.72	**6003.20**	
Assisted Living Total:						**1401600.00**
Assisted Living	day	64	365.00	60.00	**1401600.00**	
Chore Aide Total:						**9600.00**
Chore Aide	hourly	20	32.00	15.00	**9600.00**	
Environment Accessibility and Adaptation Services Total:						**25000.00**
Environment Accessibility and Adaptation Services	assessed	5	1.00	5000.00	**25000.00**	
Individual Directed Goods and Services Total:						**10000.00**
Individual Directed Goods and Services	annual	20	1.00	500.00	**10000.00**	
Occupational Therapy Total:						**0.00**
Occupational Therapy	15 minutes	0	0.00	0.01	**0.00**	
Participant-Directed Community Support Services Total:						**87312.00**
Participant-Directed Community Support Services	15 minutes	20	1070.00	4.08	**87312.00**	
Personal Emergency Response System (PERS) Total:						**1171280.00**
Personal Emergency Response System Installation	flat rate	554	1.00	40.00	**22160.00**	
Personal Emergency Response System Rental	month	3360	12.00	28.50	**1149120.00**	
Physical Therapy Total:						**0.00**
Physical Therapy	15 minutes	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**96057571.55**
Total Estimated Unduplicated Participants:	**4860**
Factor D (Divide total by number of participants):	**19764.93**
Average Length of Stay on the Waiver:	365

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:						**6037.44**
Adult Day Health	daily	4	12.00	125.78	**6037.44**	
Case Management Total:						**5785124.40**
Case Management Initial Assessment	initial assessment	92	1.00	500.00	**46000.00**	
Case Management Visit	visit	4547	8.00	125.00	**4547000.00**	
Case Management Annual Reassessment	reassessment	4860	1.00	225.00	**1093500.00**	
Case management per member per month	month	413	1.00	238.80	**98624.40**	
Homemaker Total:						**2348.80**
Homemaker	hourly	8	16.00	18.35	**2348.80**	
Personal Care Aide Total:						**43527710.03**
Personal Care Aide	15 minutes	2818	3224.70	4.79	**43527710.03**	
Respite Total:						**935236.73**
Respite 1-17 hours/day	15 minutes	274	706.80	4.79	**927646.73**	
Respite 18-24 hours/day	day	1	25.30	300.00	**7590.00**	
Assisted Living Total:						**1040376.00**
Assisted Living	day	67	258.80	60.00	**1040376.00**	
Chore Aide Total:						**1174.40**
Chore Aide	hourly	2	32.00	18.35	**1174.40**	
Environment Accessibility and Adaptation Services Total:						**100000.00**
Environment Accessibility and Adaptation Services	assessed	10	1.00	10000.00	**100000.00**	
Individual Directed Goods and Services Total:						**0.00**
Individual Directed Goods and Services	n/a	0	0.00	0.01	**0.00**	
Occupational Therapy Total:						**2652.00**
Occupational Therapy	15 minutes	24	6.80	16.25	**2652.00**	
Participant-Directed Community Support Services Total:						**1554651.00**
Participant-Directed Community Support Services	Annual	100	1.00	15546.51	**1554651.00**	
Personal Emergency Response System (PERS) Total:						**1222353.80**
Personal Emergency Response System Installation	flat rate	515	1.00	40.00	**20600.00**	
Personal Emergency Response System Rental	month	3978	10.60	28.50	**1201753.80**	

Physical Therapy Total:						**12480.00**
Physical Therapy	15 minutes	24	32.00	16.25	**12480.00**	

GRAND TOTAL:	**54190144.60**
Total Estimated Unduplicated Participants:	**4960**
Factor D (Divide total by number of participants):	**10925.43**
Average Length of Stay on the Waiver:	321

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:						**8496439.00**
Adult Day Health	daily	350	193.00	125.78	**8496439.00**	
Case Management Total:						**13814589.36**
Case Management Initial Assessment	initial assessment	0	0.00	0.01	**0.00**	
Case Management Visit	visit	0	0.00	0.01	**0.00**	
Case Management Annual Reassessment	reassessment	0	0.00	0.01	**0.00**	
Case management per member per month	month	5060	11.10	245.96	**13814589.36**	
Homemaker Total:						**2854800.00**
Homemaker	hourly	732	208.00	18.75	**2854800.00**	
Personal Care Aide Total:						**48523357.68**
Personal Care Aide	15 minutes	2928	3217.90	5.15	**48523357.68**	
Respite Total:						**1127168.07**
Respite 1-17 hours/day	15 minutes	282	770.90	5.15	**1119578.07**	
Respite 18-24 hours/day	day	1	25.30	300.00	**7590.00**	
Assisted Living Total:						**1209900.00**
Assisted Living	day	74	272.50	60.00	**1209900.00**	
Chore Aide Total:						**13200.00**
Chore Aide	hourly	22	32.00	18.75	**13200.00**	

Environment Accessibility and Adaptation Services Total:						**150000.00**
Environment Accessibility and Adaptation Services	assessed	15	1.00	10000.00	**150000.00**	
Individual Directed Goods and Services Total:						**0.00**
Individual Directed Goods and Services	n/a	0	0.00	0.01	**0.00**	
Occupational Therapy Total:						**55389.75**
Occupational Therapy	15 minutes	437	7.80	16.25	**55389.75**	
Participant-Directed Community Support Services Total:						**2320098.20**
Participant-Directed Community Support Services	Annual	140	1.00	16572.13	**2320098.20**	
Personal Emergency Response System (PERS) Total:						**1453720.10**
Personal Emergency Response System Installation	flat rate	548	1.00	40.00	**21920.00**	
Personal Emergency Response System Rental	month	4526	11.10	28.50	**1431800.10**	
Physical Therapy Total:						**228280.00**
Physical Therapy	15 minutes	439	32.00	16.25	**228280.00**	

GRAND TOTAL:	**80246942.16**
Total Estimated Unduplicated Participants:	**5060**
Factor D (Divide total by number of participants):	**15859.08**
Average Length of Stay on the Waiver:	336