

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

RECEIVED



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Region III/Division of Medicaid and Children's Health

MAA
Sr. Deputy Director

cc: R. Cosby
4/10/07

MAR 29 2007

RTM

Copy to John

Robert T. Maruca
Senior Deputy Director
Medical Assistance Administration
Department of Health
825 N. Capitol Street, NE Suite 5200
Washington, DC 20002

Re: District of Columbia's Home and Community Based Services (HCBS) Waiver for the Elderly and Physically Disabled (CMS Control #0334.90.R1)

Dear Mr. Maruca:

I am pleased to inform you that your application to renew your Medicaid Home and Community Based Services (HCBS) Elderly and Physically Disabled (EPD) Waiver has been approved. This renewal is listed with the Centers for Medicare & Medicaid Services (CMS) as Control number 0334.90.R1. Please refer to this number in all future correspondence regarding this waiver. The waiver will enable the District to continue serving individuals in the elderly population aged 65 and over and the physically disabled population aged 18 - 64 in Home and Community Based settings including Assisted Living in lieu of a Nursing Facility.

The waiver, authorized under the provisions of 1915(c) of the Social Security Act, will enable the District to provide the following home and community-based services: Case Management Services, Homemaker Services, Chore Aide Services, Personal Care Aide Services, Respite Care Services, Environmental Accessibility Adaptation Services, Personal Emergency Response System Services and Assisted Living Services. In addition, the District will provide community-based care to approximately 1,700 to 2,660 individuals as detailed below.

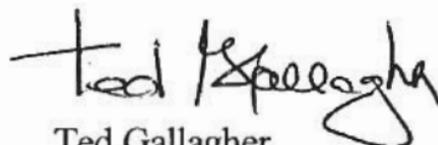
This approval is based on the assurances and information that the District has provided. It is subject to your agreement to provide home and community-based services, on an annual basis, to no more than those indicated as the value of "C" in your approved per capita expenditure estimates (shown below). In these estimates, "C" represents the unduplicated number of individuals served under the waiver during each waiver year. Factors "D" and "G" represent the estimated average annual per capita costs of waiver and institutional services, respectively.

The Medicare Modernization Act provides several new and important enhancements including a prescription drug benefit and preventive services. For more information, please call the national Medicare information line at 1-800-MEDICARE toll-free or the Philadelphia Regional Office beneficiary hot line at 215-861-4226.

Waiver Year	C Factor	D Factor Estimates	D' Factor Estimates	G Factor Estimates	G' Factor Estimates
1	1,700	\$ 6,624	\$27,403	\$49,795	\$ 3,803
2	1,940	\$ 6,444	\$30,143	\$54,774	\$ 4,183
3	2,180	\$ 6,582	\$33,157	\$60,251	\$ 4,601
4	2,420	\$ 6,546	\$37,467	\$68,083	\$ 5,199
5	2,660	\$ 6,520	\$41,213	\$74,891	\$ 5,718

We appreciate the assistance and cooperation provided by your staff throughout the renewal process and wish you every success in the operation of this waiver program. If you have any questions regarding this waiver renewal, please contact Jean Maldonado at (215) 861-4252.

Sincerely,



Ted Gallagher
Acting Associate Regional Administrator

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.3

Submitted by:

District of Columbia Department of Health, Medical Assistance Administration, Office on Disabilities and Aging

Submission Date: Old Format, October 2006 and New Format, December 6, 2006

CMS Receipt Date (CMS Use)

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:

This request serves as a renewal of the 1915(c) Elderly and Physically Disabled Waiver- Home and Community-Based Waiver Services. The request represents continuation of current services as well as proposed implementation of the following approved service:

- Assisted Living

State:	District of Columbia
Effective Date	January 4, 2007

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.

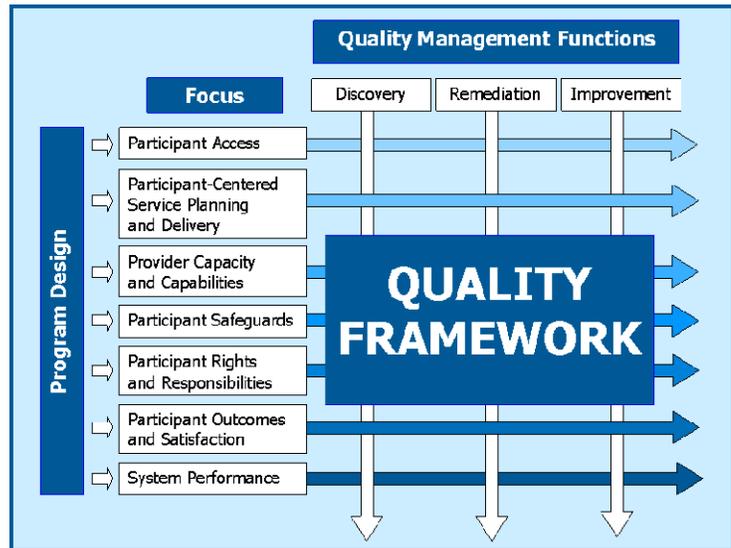
The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other 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.

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- ◆ **Participant Access:** *Individuals have access to home and community-based services and supports in their communities.*
- ◆ **Participant-Centered Service Planning and Delivery:** *Services and supports are planned and effectively implemented in accordance with each participant’s unique needs, expressed preferences and decisions concerning his/her life in the community.*
- ◆ **Provider Capacity and Capabilities:** *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- ◆ **Participant Safeguards:** *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- ◆ **Participant Rights and Responsibilities:** *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- ◆ **Participant Outcomes and Satisfaction:** *Participants are satisfied with their services and achieve desired outcomes.*
- ◆ **System Performance:** *The system supports participants efficiently and effectively and constantly strives to improve quality.*

The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework.



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1. Request Information

A. The **State** of **District 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. **Waiver Title** (optional): **Elderly and Persons with Physical Disabilities**

C. **Type of Request** (select only one):

<input type="radio"/>	New Waiver (3 Years)	CMS-Assigned Waiver Number (CMS Use):	
<input type="radio"/>	New Waiver (3 Years) to Replace Waiver #		
	CMS-Assigned Waiver Number (CMS Use):		
	<i>Attachment #1 contains the transition plan to the new waiver.</i>		
<input checked="" type="radio"/>	Renewal (5 Years) of Waiver #	0334.	
<input type="radio"/>	Amendment to Waiver #		

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

<input type="radio"/>	Model Waiver. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
<input checked="" type="radio"/>	Regular Waiver , as provided in 42 CFR §441.305(a)

E.1 **Proposed Effective Date:** **January 04, 2007**

E.2 **Approved Effective Date** (CMS Use):

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):

<input type="checkbox"/>	Hospital (select applicable level of care)
<input type="radio"/>	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:
<input type="radio"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
<input checked="" type="checkbox"/>	Nursing Facility (select applicable level of care)
<input checked="" type="radio"/>	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:
<input type="radio"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
<input type="checkbox"/>	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:

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

<input type="checkbox"/>	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I		
<input type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>		
	Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):		
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	X	§1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i>		
X	Not applicable		

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.

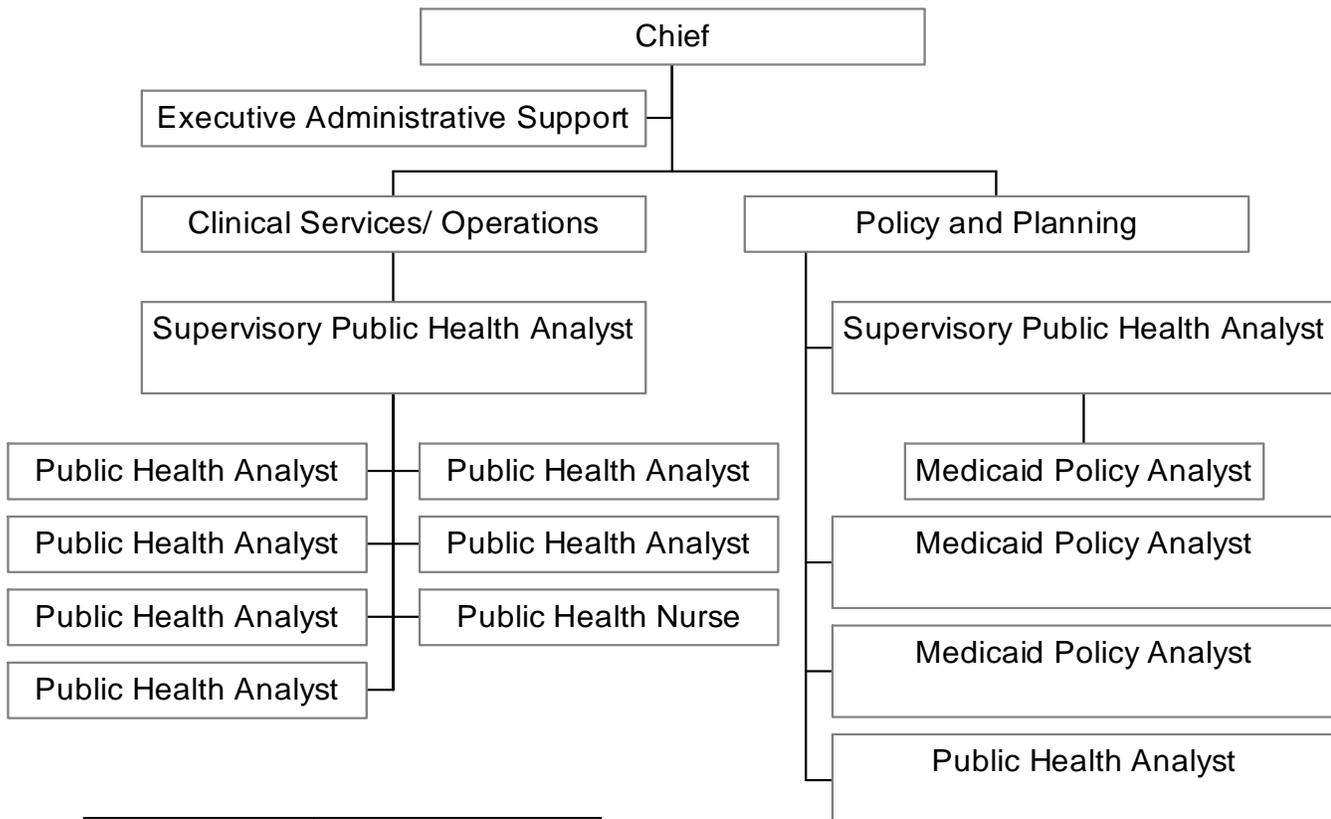
<p>PURPOSE: The Elderly and Persons with Physical Disabilities (EPD) Waiver seeks to continue serving individuals in the Elderly population aged 65 and over and the Physically disabled population aged 18 – 64 in Home and Community Based Settings including Assisted Living in lieu of a Nursing Facility.</p> <p>GOAL: The goal of the program is to ensure that the above named populations are provided with in-home supports which will allow individuals to remain in the confines of their personal domicile with assistance in attaining their activities of daily living. Assisted Living will also be added to the EPD Waiver.</p> <p>OBJECTIVES:</p> <ul style="list-style-type: none"> ▪ To ensure the target population remains in their personal home with supports ▪ To enhance the quality of life for person who are elderly and persons with physical disabilities ▪ To expand the range of health care services for said population. <p>ORGANIZATIONAL STRUCTURE: The Medical Assistance Administration Office on Disabilities and Aging is responsible for administration of the waiver and its process. [SEE ATTACHED]</p> <p>SERVICE DELIVERY METHODS: Provider agencies who are interested in provision of services to the District of Columbia for the Elderly and Persons with Physical Disabilities waiver program are required to submit an application so as to obtain contractual agreements. Home and community based services have defined populations and specific rules that are outlined for the implementation of services.</p> <ul style="list-style-type: none"> • The application and a set of waiver rules are mandatory for the process to begin and are given to

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potential providers who are Home Health agencies, Case Management agencies, and community service providers who are able to meet the criteria for appropriate provision of service.

- Upon approval for the program the agencies are provided with orientation to the program a CD that contains the forms and instructions necessary for waiver provision of services. Additionally, agencies are given technical assistance, as needed.
- Agencies are also provided with a billing manual and orientation for the billing process
- Agencies are given the responsibilities of assessment for the participant
- Registered Nurses and Case managers are responsible for the assessment of the participant
- Registered Nurses are responsible for the Level of Care approvals for the participant Level of Care approvals that are given by the Quality Improvement Organization Delmarva.
- Beneficiary Freedom of Choice forms, Individual Service Plans, a Health History, and the Cost Sheets are completed by the case manager.
- Eligibility is determined by the Income Maintenance Administration who actually certifies the participants as eligible for the program
- All required documentation for the participant’s service request are sent to ODA and reviewed for appropriateness of documentation, service approvals, as well as cogent community linkages.
- General Provisions for the actual administrative and operational process of the waiver services are governed by the District of Columbia Municipal Regulations. Regulations governing reimbursement were published in the D.C. Register on June 6, 2003, District of Columbia Municipal Regulations (DCMR), Title 29 Chapter 42 entitled Home and Community-Based Waiver Service for Persons who are Elderly and Individuals with Physical Disabilities.

MAA- Office on Disabilities and Aging Organizational Chart - November 2006



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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*):

O	The waiver provides for participant direction of services. <i>Appendix E is required.</i>
X	Not applicable. The waiver does not provide for participant direction of services. <i>Appendix E is not completed.</i>

- 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 Management Strategy.** Appendix H contains the Quality Management 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.

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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*):

<input checked="" type="radio"/>	Yes
<input type="radio"/>	No
<input type="radio"/>	Not applicable

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

<input type="radio"/>	Yes (<i>complete remainder of item</i>)
<input checked="" type="radio"/>	No

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

<input type="checkbox"/>	<p>Geographic Limitation. A waiver of statewide 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. <i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p>
<input type="checkbox"/>	<p>Limited Implementation of Participant-Direction. A waiver of statewide is requested in order to make <i>participant direction of services</i> 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. <i>Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p>

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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

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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 Improvement Act of 2004 (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) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

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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 amount, frequency and duration 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/MR.
- 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 §431.51, 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 Management.** 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

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and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management 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 at its inception. Quarterly Case Managers, Providers, and Community advocates are invited to Waiver meetings to assess the services. Additionally, public input was solicited from the District’s Council and a special Health Committee Task Force provided input. An Aging and Disabilities committee with MAA-ODA Staff provided the impetus for streamlining documentation necessary for the Waiver process.

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 as 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 Participant 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:

First Name:	Robert
Last Name	Cosby
Title:	Chief, Office on Disabilities and Aging
Agency:	District of Columbia Department of Health
Address 1:	825 North Capitol Street, NE
Address 2:	Suite 5135
City	Washington
State	DC
Zip Code	20002
Telephone:	202-442-5972
E-mail	Robert.cosby@dc.gov
Fax Number	202-442-4799

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

First Name:	N/A
Last Name	
Title:	
Agency:	

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Application for a §1915(c) HCBS Waiver
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Address 1:	
Address 2	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

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8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____ **Date:** _____
 State Medicaid Director or Designee

First Name:	Robert
Last Name	Maruca
Title:	Senior Deputy Director
Agency:	Medical Assistance Administration, D.C. Department of Health
Address 1:	825 North Capitol Street, NE
Address 2:	Suite 5135
City	Washington
State	DC
Zip Code	20002
Telephone:	202-442-5988
E-mail	robert.maruca@dc.gov
Fax Number	202-442-4790

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Attachment #1: Transition Plan

Specify the transition plan for the waiver:

N/A

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Effective Date	January 4, 2007

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*):

<input checked="" type="checkbox"/>	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 (<i>select one; do not complete Item A-2</i>):	
<input checked="" type="checkbox"/>	The Medical Assistance Administration (<i>name of unit</i>):	Office on Disabilities and Aging
<input type="checkbox"/>	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit)	
<input type="checkbox"/>	The waiver is operated by _____ a separate agency of the State that is not a division/unit of the Medicaid agency. 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. <i>Complete item A-2.</i>	

2. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, 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:

N/A

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

<input checked="" type="checkbox"/>	Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. <i>Complete Items A-5 and A-6.</i>
	Delmarva Foundation serves as the Medicaid Quality Improvement Organization (QIO) and performs all Nursing Home Level of Care reviews.
<input type="checkbox"/>	No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

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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 (*check each that applies*):

<input type="checkbox"/>	<p>Local/Regional non-state public agencies conduct waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i></p>
<input type="checkbox"/>	<p>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). <i>Specify the nature of these entities and complete items A-5 and A-6:</i></p>
<input checked="" type="checkbox"/>	<p>Not applicable – Local/regional non-state agencies do not perform waiver operational and administrative functions.</p>

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:

<p>Annually the Medicaid Office conducts an on-site survey/audit of each Home Health Agency. The MAA-Office on Disabilities and Aging is responsible for the survey/audit. In addition, the Health Regulation and Licensing Administration conduct annual on-site audits of each Home Health Agency. The State conducts monthly meetings with Quality Improvement Agency Delmarva to ensure the identified contractual items are reviewed. ODA receives a monthly report on identified items as addressed in the contract. Level of Care (LOC) determination reports, Nursing facility census, both in-state and out of State, Continued stay reviews in state and out of state, paper reviews on the certifications and reassessment of the participants in the Nursing Facilities, Day treatment, and EPD LOC. Annually, the State Office of Contracts and Procurement conduct an audit/satisfaction survey on the performance of the Delmarva Foundation.</p> <p>The Medical Assistance Administration Quality Management Agency also conducts a formal performance review of Delmarva performance.</p> <p>Delmarva Foundation also submits an annual performance measure tool to be completed by the state as a mechanism to assess their performance. ODA completes the tool with candid responses.</p>
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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:

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Appendix A: Waiver Administration and Operation

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Methodologies used to conduct the audits include: Audits are conducted annually and as necessary using specific instrumentation as identified below:

- A tool for service utilization
- On-site review of Direct Care personnel records
- On-site review of participant charts
- On-site review of direct care personnel time sheets
- On-site review of policies and procedures of agency operations to ensure Waiver functions are conducted in accordance with approved contractual agreements. The on-site monitoring is conducted annually by two different entities, the Medicaid Office and the State licensure and regulatory agency (Health Regulation and Licensing Administration).
- Telephone survey of customers
- Telephone survey of response time for calls
- Review of all customers' applications for admission (ongoing)

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.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assist individuals in waiver enrollment	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage waiver enrollment against approved limits	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monitor waiver expenditures against approved levels	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct level of care evaluation activities	X	<input type="checkbox"/>	X	<input type="checkbox"/>
Review participant service plans to ensure that waiver requirements are met	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform prior authorization of waiver services	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct utilization management functions	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recruit providers	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Execute the Medicaid provider agreement	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Determine waiver payment amounts or rates	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct training and technical assistance concerning waiver requirements	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Appendix B: Participant Access and Eligibility

Appendix 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 a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

INCLUDED	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
<input type="radio"/>	Aged or Disabled, or Both			
<input checked="" type="checkbox"/>	Aged (age 65 and older)	65	-	<input type="checkbox"/>
<input checked="" type="checkbox"/>	Disabled (Physical) (under age 65)	18	64	
<input type="checkbox"/>	Disabled (Other) (under age 65)			
Specific Aged/Disabled Subgroup				
<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="radio"/>	Mental Retardation or Developmental Disability, or Both			
<input type="checkbox"/>	Autism			<input type="checkbox"/>
<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
<input type="checkbox"/>	Mental Retardation			<input type="checkbox"/>
<input type="radio"/>	Mental Illness			
<input type="checkbox"/>	Mental Illness (age 18 and older)			<input type="checkbox"/>
<input type="checkbox"/>	Serious Emotional Disturbance (under age 18)			

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

The group is inclusive of elderly and disabled persons who all meet at least the functional criteria for admission to the nursing 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*):

<input type="radio"/>	Not applicable – There is no maximum age limit
<input checked="" type="checkbox"/>	The following transition planning procedures are employed for participants who will reach the waiver’s maximum age limit (<i>specify</i>): The maximum age for physical disability is age 64. However, the age for elderly is inclusive for all 65 or above. Those individuals who reach the 64 age limit while in the Waiver disability category are transitioned into the Elderly category of the Waiver upon reaching age 65.

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Appendix B-2: Individual Cost Limit

- 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*):

<input checked="" type="checkbox"/>		No Cost Limit. The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>
<input type="checkbox"/>		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. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is (<i>select one</i>):
<input type="checkbox"/>		%, a level higher than 100% of the institutional average
<input type="checkbox"/>		Other (<i>specify</i>):
<input type="checkbox"/>		
<input type="checkbox"/>		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. <i>Complete Items B-2-b and B-2-c.</i>
<input type="checkbox"/>		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. <i>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.</i>
<input type="checkbox"/>		
<input type="checkbox"/>		The cost limit specified by the State is (<i>select one</i>):
<input type="checkbox"/>		The following dollar amount: \$
<input type="checkbox"/>		The dollar amount (<i>select one</i>):
<input type="checkbox"/>		Is adjusted each year that the waiver is in effect by applying the following formula:
<input type="checkbox"/>		
<input type="checkbox"/>		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.
<input type="checkbox"/>		The following percentage that is less than 100% of the institutional average:
<input type="checkbox"/>		%
<input type="checkbox"/>		Other – <i>Specify</i> :
<input type="checkbox"/>		

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- 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:

N/A

- 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*):

<input type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual’s needs.
<input type="checkbox"/>	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:
	N/A
<input type="checkbox"/>	Other safeguard(s) (<i>specify</i>):

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Appendix B-3: Number of Individuals Served

- 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	1,700
Year 2	1,940
Year 3	2,180
Year 4 (renewal only)	2,420
Year 5 (renewal only)	2,660

- 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*):

<input type="radio"/>	The State does not limit the number of participants that it serves at any point in time during a waiver year.
<input checked="" type="radio"/>	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	1,700
Year 2	1,940
Year 3	2,180
Year 4 (renewal only)	2,420
Year 5 (renewal only)	2,660

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- 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*):

<input checked="" type="checkbox"/>	Not applicable. The state does not reserve capacity.	
<input type="checkbox"/>	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:	
	The capacity that the State reserves in each waiver year is specified in the following table:	
	Table B-3-c	
	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Waiver Year		
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

- 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*):

<input checked="" type="checkbox"/>	The waiver is not subject to a phase-in or a phase-out schedule.
<input type="checkbox"/>	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 <i>intra-year</i> limitation on the number of participants who are served in the waiver.

- e. Allocation of Waiver Capacity.** *Select one:*

<input checked="" type="checkbox"/>	Waiver capacity is allocated/managed on a statewide basis.
<input type="checkbox"/>	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:

Waiver criteria are: 1) a District of Columbia resident; 2) a Medicaid recipient with income up to 300 % of SSI; and 3) Meets functional criteria of needing assistance with at least 2 ADLs and 3 IADLs. We use a Wait list, First come, first served basis.

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Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

<input checked="" type="radio"/>	§1634 State
<input type="radio"/>	SSI Criteria State
<input type="radio"/>	209(b) State

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:*

<i>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</i>	
<input type="checkbox"/>	Low income families with children as provided in §1931 of the Act
<input checked="" type="checkbox"/>	SSI participant
<input type="checkbox"/>	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
<input checked="" type="checkbox"/>	Optional State supplement participant
<input checked="" type="checkbox"/>	Optional categorically needy aged and/or disabled individuals who have income at: (<i>select one</i>)
<input checked="" type="checkbox"/>	100% of the Federal poverty level (FPL)
<input type="checkbox"/>	% of FPL, which is lower than 100% of FPL
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
<input type="checkbox"/>	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)
<input type="checkbox"/>	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)
<input checked="" type="checkbox"/>	Medically needy
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify:</i>
<i>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</i>	
<input type="checkbox"/>	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.
<input checked="" type="checkbox"/>	Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>
<input type="checkbox"/>	All individuals in the special home and community-based waiver group under 42 CFR §435.217

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<input checked="" type="checkbox"/>	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 (<i>check each that applies</i>):		
<input checked="" type="checkbox"/>	A special income level equal to (select one):		
<input checked="" type="checkbox"/>		300% of the SSI Federal Benefit Rate (FBR)	
<input type="checkbox"/>	○	%	of FBR, which is lower than 300% (42 CFR §435.236)
<input type="checkbox"/>	○	\$	which is lower than 300%
<input type="checkbox"/>	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)		
<input type="checkbox"/>	Medically needy without spenddown in States which also provide Medicaid to participant of SSI (42 CFR §435.320, §435.322 and §435.324)		
<input type="checkbox"/>	Medically needy without spend down in 209(b) States (42 CFR §435.330)		
<input checked="" type="checkbox"/>	Aged and disabled individuals who have income at: (<i>select one</i>)		
<input checked="" type="checkbox"/>		100% of FPL	
<input type="checkbox"/>	○	%	of FPL, which is lower than 100%
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :		

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Appendix B-5: Post-Eligibility Treatment of Income

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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 (*select one*):

<input checked="" type="checkbox"/>	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 (<i>select one</i>):	
<input checked="" type="checkbox"/>		Use <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>Complete Items B-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.</i>
<input type="checkbox"/>		Use <i>regular</i> post-eligibility rules under 42 CFR §435.726 (SSI State) (<i>Complete Item B-5-b-1</i>) or under §435.735 (209b State) (<i>Complete Item B-5-c-1</i>). <i>Do not complete Item B-5-d.</i>
<input type="checkbox"/>	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. <i>Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.</i>	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. 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 (<i>select one</i>):		
<input type="checkbox"/>	The following standard included under the State plan (<i>select one</i>):	
<input type="checkbox"/>		SSI standard
<input type="checkbox"/>		Optional State supplement standard
<input type="checkbox"/>		Medically needy income standard
<input type="checkbox"/>	The special income level for institutionalized persons (<i>select one</i>):	
<input type="checkbox"/>		0 300% of the SSI Federal Benefit Rate (FBR)
<input type="checkbox"/>		% of the FBR, which is less than 300%
<input type="checkbox"/>		\$ which is less than 300%.
<input type="checkbox"/>		% of the Federal poverty level
<input type="checkbox"/>	Other (specify):	
<input type="checkbox"/>		

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<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
ii. Allowance for the spouse only (select one):			
<input type="radio"/>	SSI standard		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Not applicable (see instructions)		
iii. Allowance for the family (select one):			
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following 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.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Other (specify):		
<input type="radio"/>	Not applicable (see instructions)		
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. <i>Select one:</i>			
<input type="radio"/>	The State does not establish reasonable limits.		
<input type="radio"/>	The State establishes the following reasonable limits (specify):		

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c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant’s income:

i. Allowance for the needs of the waiver participant (<i>select one</i>):			
<input type="radio"/>	The following standard included under the State plan (<i>select one</i>)		
<input type="radio"/>	The following standard under 42 CFR §435.121:		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons (<i>select one</i>)		
<input type="radio"/>		300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	%		of the FBR, which is less than 300%
<input type="radio"/>	\$		which is less than 300% of the FBR
<input type="radio"/>	%		of the Federal poverty level
<input type="radio"/>	Other (specify):		
<input type="radio"/>	The following dollar amount: \$ _____ If this amount changes, this item will be revised.		
<input type="radio"/>	The following formula is used to determine the needs allowance:		
ii. Allowance for the spouse only (<i>select one</i>):			
<input type="radio"/>	The following standard under 42 CFR §435.121		
<input type="radio"/>	Optional State supplement standard SSI		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount: \$ _____ If this amount changes, this item will be revised.		
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Not applicable (<i>see instructions</i>)		
iii. Allowance for the family (<i>select one</i>):			
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		

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<input type="radio"/>	The following 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.
<input type="radio"/>	The amount is determined using the following formula: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="radio"/>	Other (specify): <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="radio"/>	Not applicable (see instructions)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:	
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. <i>Select one:</i>	
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>): <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules and elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. 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: **See Attachment – Post Eligibility General Instructions.**

i. Allowance for the needs of the waiver participant (<i>select one</i>):		
<input checked="" type="checkbox"/>	The following standard included under the State plan (<i>select one</i>)	
<input type="checkbox"/>	SSI standard	
<input type="checkbox"/>	Optional State supplement standard	
<input type="checkbox"/>	Medically needy income standard	
<input checked="" type="checkbox"/>	The special income level for institutionalized persons (<i>select one</i>):	
<input checked="" type="checkbox"/>	X	300% of the SSI Federal Benefit Rate (FBR)
<input type="checkbox"/>	%	of the FBR, which is less than 300%
<input type="checkbox"/>	\$	which is less than 300%.
<input type="checkbox"/>	%	of the Federal poverty level
<input type="checkbox"/>	Other (specify):	

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<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
ii. Allowance for the spouse only (<i>select one</i>):			
<input type="radio"/>	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 the amount of the allowance:			
<input type="radio"/>	SSI standard		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input checked="" type="checkbox"/>	Not applicable		

Attachment to Appendix B -- Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver participant found eligible under §435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic predetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State must use the regular post-

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eligibility rules at §435.726 and §435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under §1924.

REGULAR POST-ELIGIBILITY RULES--§435.726 and §435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.
- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.
- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--§1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in §1902 (q) (1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

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Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

iii. Allowance for the family (select one):	
<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ <input style="width: 50px;" type="text"/> 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.
<input type="radio"/>	The amount is determined using the following formula: <input style="width: 100%; height: 20px;" type="text"/>
<input type="radio"/>	Other (specify): <input style="width: 100%; height: 20px;" type="text"/>
<input checked="" type="checkbox"/>	Not applicable (see instructions)
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. <i>Select one:</i>	
<input checked="" type="checkbox"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (specify): <input style="width: 100%; height: 20px;" type="text"/>

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 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 amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):	
<input type="radio"/>	The following standard included under the State plan (select one)
<input type="radio"/>	The following standard under 42 CFR §435.121: <input style="width: 100%; height: 20px;" type="text"/>
<input type="radio"/>	Optional State supplement standard

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<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons (<i>select one</i>)		
<input type="radio"/>	300%	of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	%	of the FBR, which is less than 300%	
<input type="radio"/>	\$	which is less than 300% of the FBR	
<input type="radio"/>	%	of the Federal poverty level	
<input type="radio"/>	Other (specify):		
<input type="radio"/>	The following dollar amount: \$ _____ If this amount changes, this item will be revised.		
<input type="radio"/>	The following formula is used to determine the needs allowance:		
ii. Allowance for the spouse only (<i>select one</i>):			
<input type="radio"/>	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 the amount of the allowance:			
<input type="radio"/>	The following standard under 42 CFR §435.121:		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$ _____	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Not applicable		
iii. Allowance for the family (<i>select one</i>):			
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following 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.
<input type="radio"/>	The amount is determined using the following formula:		

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<input type="radio"/>	Other (specify):
<input type="radio"/>	Not applicable (see instructions)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735: N/A	
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. <i>Select one:</i>	
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):

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, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. Allowance for the personal needs of the waiver participant (<i>select one</i>): N/A	
<input type="radio"/>	SSI Standard
<input type="radio"/>	Optional State Supplement standard
<input type="radio"/>	Medically Needy Income Standard
<input checked="" type="radio"/>	The special income level for institutionalized persons
<input type="radio"/>	% of the Federal Poverty Level
<input type="radio"/>	The following dollar amount: \$ If this amount changes, this item will be revised
<input type="radio"/>	The following formula is used to determine the needs allowance:
<input type="radio"/>	Other (<i>specify</i>):
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. <i>Select one:</i>	
<input checked="" type="radio"/>	Allowance is the same
<input type="radio"/>	Allowance is different. Explanation of difference:

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	<p>iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:</p>
	<p>a. Health insurance premiums, deductibles and co-insurance charges.</p> <p>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. <i>Select one:</i></p>
X	The State does not establish reasonable limits.
○	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

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Appendix 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 waiver 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 (<i>insert number</i>):
	1	
ii.	Frequency of services.	The State requires (<i>select one</i>):
<input type="radio"/>		The provision of waiver services at least monthly
<input checked="" type="radio"/>		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*):

<input type="radio"/>	Directly by the Medicaid agency
<input type="radio"/>	By the operating agency specified in Appendix A
<input checked="" type="radio"/>	By an entity under contract with the Medicaid agency. <i>Specify the entity:</i>
	Performance of Medicaid Level of Care is conducted annually by the State Quality Improvement Organization, currently Delmarva Foundation.
<input type="radio"/>	Other (<i>specify</i>):
	Periodic Re-evaluation may occur if necessary case managers are responsible for ensuring that annual and PRN Level of Care re-evaluations are conducted.

- 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 is performed by <ul style="list-style-type: none"> A Physician (MD or D.D) Registered Nurse, Licensed in the State Licensed Social Worker Case Manager pursuant to case management standards
--

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- 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.

The agency will provide for an evaluation and periodic re-evaluation at least annually, of the need for a level of care noted as nursing home level, when there is a reasonable indication that individuals might need such 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 of the criteria used to determine the level of assistance the participant will need. The criteria for the level of care are:

- Bathing
- Dressing
- Overall mobility
- Eating
- Toilet use
- Medication management
- Meal preparation
- Housekeeping
- Money Management
- Using telephone

Activities of daily living (ADLs) are noted as items one through five
 Instrumental Activities of Daily Living (IADL)

- 1) Independent – (need 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 (may help bur cannot perform without help from staff or cannot do for self at all)

Minimum Standard:

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

- 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*): **See Attachment – Referral for Medicaid Level of Care**

<input checked="" type="radio"/>	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
<input type="radio"/>	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.

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Attachment to Appendix B
Government of the District of Columbia -Department of Health
Referral for Medicaid Level of Care

(1) _____ / _____ / _____ (2) SS# _____ - _____ - _____ (3) MA # _____
 Date of Referral

(4) Certification Requested	<input type="checkbox"/>	Medical Day Care	<input type="checkbox"/>	Nursing Facility	<input type="checkbox"/>	CRF	<input type="checkbox"/>	Elderly and Physical Disabilities Waiver	
(5) Reason for Referral	<input type="checkbox"/>	Initial Placement	<input type="checkbox"/>	Transfer from NF to NF or Waiver	<input type="checkbox"/>	Conversion to Medicaid			
	<input type="checkbox"/>	Return within bed hold							

Part A

(6) Name of Individual _____
 Last First MI

(7) Permanent Address (include name of NF, if applicable) _____

(8) Phone (_____) _____ - _____ (9) DOB _____ / _____ / _____ (10) Sex _____

(11) Marital Status - Please Circle One: Single, Married, Divorced, And Widowed

(12) Responsible Party / Next of Kin _____
 Last First

(13) Address _____

(14) Present Location of Individual (Name and Address of Hospital/NF/Community if different from above) _____

Part B - Individual Profile (Referring Source - Health Care Professional to complete)
Code X = Yes - (Please only check one level of assistance per activity)

C

Independent (Needs no help)	Supervision or Limited Assistance (Needs oversight, encouragement or cueing OR highly involved in activity but needs assistance)	Extensive Assistance or Totally Dependent (May help but cannot perform without help from staff OR cannot do for self at all)
Activities of Daily Living (ADLs)		
(15) Bathing	<input type="checkbox"/>	<input type="checkbox"/>
(16) Dressing	<input type="checkbox"/>	<input type="checkbox"/>
(17) Overall Mobility	<input type="checkbox"/>	<input type="checkbox"/>
(18) Eating	<input type="checkbox"/>	<input type="checkbox"/>
(19) Toilet Use	<input type="checkbox"/>	<input type="checkbox"/>
Instrumental Activities of Daily Living (IADLs)		
(20) Medication Management	<input type="checkbox"/>	<input type="checkbox"/>
(21) Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>
(22) Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>
(23) Money Management	<input type="checkbox"/>	<input type="checkbox"/>
(24) Using Telephone	<input type="checkbox"/>	<input type="checkbox"/>

(25) Person Completing Form _____

(26) Title _____

(27) Telephone Number (_____) _____ - _____ (28) Date Signed ____ / ____ / ____

(29) See Attached

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Patient Name _____ MA # _____

Part C Physician's Certification I attest that this patient no longer requires acute care and is in need of the above services.

(30) Physicians Name _____	(31) Signature _____
(32) Address _____	(33) Phone (_____) ____ - ____
(34) Date _____/_____/_____	

Part D - To be Completed by Agent

(35) Level of Care _____	(36) Days Assigned _____
(37) Authorized Signature _____	(38) Date _____/_____/_____
(39) Comments _____ _____	

Part E - (Receiving Facility Completes)

(40) Payment Start _____/_____/_____ Date Requested	(41) Facility/Agency Name _____
(42) Signature _____	(43) Title _____
(44) Date _____/_____/_____	(45) Bed hold Days Remaining _____

Delmarva Foundation, Inc.
1620 L Street, N.W.
Suite 1275
Washington, DC 20036
Telephone: (202) 293-9650
ALL FORMS ARE TO BE FAXED TO THE HANOVER, MD OFFICE
FAX: (800) 971-8101
TEL: (800) 876-3362

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- 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:

Identification is of daily care needs. A functional assessment is initially performed using identified instrument. Noted as attached in Appendix B – Participant Access and Eligibility. Assessments are conducted annually. Approvals for the Level of Care are performed by the Quality Improvement Organization. Case Managers are responsible for ensuring that annual and as needed Level of Care re-evaluations are conducted.

- 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*):

<input type="radio"/>	Every three months
<input type="radio"/>	Every six months
<input checked="" type="radio"/>	Every twelve months
<input type="radio"/>	Other schedule (<i>specify</i>):

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

<input checked="" type="radio"/>	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
<input type="radio"/>	The qualifications are different. The qualifications of individuals who perform reevaluations are (<i>specify</i>):

- 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*):

Case managers will be responsible for ensuring that annual and as needed Level of Care re-evaluations are conducted and reported to State agency.

- 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 §74.53. 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 maintained by the Medicaid agency in its central office.

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Appendix 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). **See attached form for Beneficiary**

For individuals determined to be likely to require a level of care indicated in this request the individual or his/her legal guardian will be

- informed of any feasible alternatives under the Waiver
 1. Choice of provider agency
 2. Choice of case managers
- given the choice of either institutional or Home and Community Based Services

- b. **Maintenance of Forms.** Per 45 CFR §74.53, 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 Documentation are maintained in:

- District of Columbia State Medicaid Office

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Attachment to Appendix B-7 Freedom of Choice

**WAIVER BENEFICIARY FREEDOM OF CHOICE FORM
AND
PROCEDURE FOR ASSURING BENEFICIARY FREEDOM OF CHOICE**

Name of Client: _____

I. Informed Beneficiary Certification

This is to certify that a representative of (name of agency) _____ has informed the potential waiver beneficiary and his or her authorized representative of (a) the potential beneficiary's right to choose between nursing facility care and home and community-based service under the approved home and community-based services waiver; and (b) the potential beneficiary's right to select his/her service provider(s) and case manager once approved to receive waiver services, and (c) the Medical Assistance Administration reserves the right to impose utilization control, service limits and other restrictions as warranted.

Signature of Agency Representative

Date

II. Beneficiary Election

This is to attest that I, _____ and/or my authorized Representative _____ have been informed of the right to choose between nursing facility care and home and community-based services under the approved waiver and have chosen the option indicated on the selected line below.

Nursing Facility Care _____

Home and Community-Based Services _____

Signed: _____
Beneficiary

Date

Signed: _____
Authorized Representative

Date

III. Witness (at least one is required):

NOTE: IT IS A CONFLICT OF INTEREST FOR THE CASE MANAGER TO WITNESS THIS FORM

We, the undersigned, attest that we have witnessed the beneficiary and his/her representative (if applicable) sign this form indicating that the beneficiary and his/her representative have been informed of the right to select either nursing facility or home and community-based services, and that the beneficiary and his/her authorized representative have indicated the above election.

Signed: _____
Witness #1

Date

Signed: _____
Witness #2

Date

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BILL OF RIGHTS & RESPONSIBILITIES

RIGHTS

As a home and community-based services customer, you have the right to be informed of your rights and responsibilities before the initiation of home and community-based services. If a customer has been deemed incompetent to make health care decisions, the customer's family and/or representative may exercise the right to make informed decisions for the customer.

As a home and community-based services customer, you have the right to:

1. Be informed in advance about the proposed services and be provided a response to questions in understandable terms.
2. Receive services appropriate to your needs, and expect the provider to render safe, professional services at the level of intensity needed without unlawful restriction by reason of age, sex, religion, race, color, creed, national origin, place of residence, sexual orientation, or disability.
3. Receive in writing and orally in advance of care, the services offered, coverage of the services by the payment source, a statement of charges and items not covered by the payment source, and any changes in charges or items and services within 15 days after the provider is aware of a change.
4. Obtain a reasonable response to request for services within the capacity of the provider to respond.
5. Have knowledge of available choices of providers, to participate in your care planning from admission to discharge, and to be informed in a reasonable time of anticipated discharge and/or transfer of services.
6. Receive services from staff that are qualified through education and/or experience to render the services to which they are assigned.
7. Know who is responsible for and who is providing care, and to receive information concerning your continuing health needs and choices for meeting those needs, and to be involved in discharge planning, if appropriate.
8. Receive reasonable continuity of care.
9. Refuse treatment to the extent provided by law, and to be informed of the medical consequences of that refusal.
10. Receive confidential treatment of your clinical records in accordance with legal requirements, and to be responsible for prior authorizing any release of information contained therein.
11. Treated with consideration, respect, and dignity, including the provision of privacy during the provision of services.
12. Inspect or receive, for a reasonable fee, a copy of your clinical records; to have information in your clinical record corrected (as appropriate); and to transfer information to any third party, unless against medical advice.
13. Receive available information about community resources that are best suited to your care needs
14. Present grievances and/or recommend changes in your services without fear of discrimination, reprisal, restraint, interference, or coercion.
15. Filing a grievance or complaint is not a pre-requisite or substitute for a fair hearing.

RESPONSIBILITIES

Each customer who is receiving home and community-based services has the responsibility to:

1. Provide a complete and accurate health history and any changes in condition, insurance, address, phone number, and other pertinent information.
2. Indicate level of understanding of the plan of care and other expectations in the provision of services
3. Comply with the prescribed plan of care
4. Treat the providers of services with dignity, courtesy, and respect
5. Notify the provider if unavailable for scheduled visits

Signature of Customer/Representative
Bill of Rights Revised 03/05/07

Signature/Title of Provider

Date

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Description of Procedures Assuring Beneficiary Freedom of Choice Policy

Under an approved home and community-based waiver program, each potential beneficiary or his/her authorized representative will be offered the choice to received home and community-based waiver services or institutional care prior placement. (A potential beneficiary is considered any individual eligible under an approved waiver whom an agency is considering for placement.)

MAA is not required to offer choice if the needs of the individual are not appropriate for waiver services, as determined by the ISP.

Through the form previously attached (Waiver Beneficiary Freedom of Choice Form), notification will be made and documentation will be maintained. However, a potential beneficiary's choice should not be based solely on verbal expression and should take into account non-verbal expression and behavioral reactions. When possible, site visits should be arranged before the final choice is made.

Procedures

The case manager will present the waiver Beneficiary Freedom of Choice form to the potential beneficiary or his/her authorized representative after an evaluation of the beneficiary has been completed and upon the determination and notification of the needed level of care, i.e., the beneficiary is eligible to participate in waiver services. This includes both a determination that the individual meets the eligibility requirements of the Medicaid Program as well as requires the level of care which can be provided through the Medicaid program. The case manager will explain to the beneficiary/representative the alternative programs designed to provide care.

The Case manager should complete the "Informed Beneficiary" section o: the form, while the beneficiary and/or representative should complete the "Beneficiary Choice" section. Two witnesses are required to sign the form attesting to the presentation of alternatives and the understanding of the beneficiary of his/her representative.

Once the form has been signed, the original copy should be retained in the centrally maintained medical record at MAA, the beneficiary should receive a copy as should the case manager.

Based on the choice of services, the case manager should take appropriate steps to secure the level of care needed for the beneficiary.

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Appendix B-8: Access to Services by Limited English Proficient 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 Participant 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
- 4204.1 – Each provider of Waiver services shall establish a plan to adequately provide services to non English speaking participant. 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 need of the recipient.

NOTE: The District of Columbia Medical Assistance Administration offers information on language and interpreter service.

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Appendix C-1: Summary of Services Covered

- a. **Waiver Services Summary.** Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *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:*

Statutory Services (check each that applies)		
Service	Included	Alternate Service Title (if any)
Case Management	X	
Homemaker	X	
Home Health Aide	<input type="checkbox"/>	
Personal Care Aide	X	
Adult Day Health	<input type="checkbox"/>	
Habilitation	<input type="checkbox"/>	
Residential Habilitation	<input type="checkbox"/>	
Day Habilitation	<input type="checkbox"/>	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	<input type="checkbox"/>	
Supported Employment	<input type="checkbox"/>	
Education	<input type="checkbox"/>	
Respite	X	
Day Treatment	<input type="checkbox"/>	
Partial Hospitalization	<input type="checkbox"/>	
Psychosocial Rehabilitation	<input type="checkbox"/>	
Clinic Services	<input type="checkbox"/>	
Live-in Caregiver (42 CFR §441.303(f)(8))	<input type="checkbox"/>	
Other Services (select one)		
<input type="radio"/>	Not applicable	
<input checked="" type="radio"/>	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute (<i>list each service by title</i>):	
a.	Environmental Adaptation and Accessibility	
b.	Personal Emergency Response Services	

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c.	Assisted Living
d.	Chore Services
e.	
f.	
g.	
h.	
i.	

Extended State Plan Services (select one)

<input type="radio"/>	Not applicable
<input type="radio"/>	The following extended State plan services are provided (<i>list each extended State plan service by service title</i>):
a.	
b.	
c.	

Supports for Participant Direction (select one)

	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
X	Not applicable

Support	Included	Alternate Service Title (if any)

Other Supports for Participant Direction (list each support by service title):

a.	
b.	
c.	

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b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants (*check each that applies*):

<input type="checkbox"/>	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As an administrative activity. <i>Complete item C-1-c.</i>
<input type="checkbox"/>	Not applicable – Case management is not furnished as a distinct activity to waiver participants. <i>Do not complete Item C-1-c.</i>

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

Case Management functions are provided by Home Health Agencies, Case Management Agencies as Medicaid provider agencies for the District of Columbia Medical Assistance Administration. Each of these agencies provide the function on behalf of Waiver participants.

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Appendix C-2: General Service Specifications

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*):

<input checked="" type="checkbox"/>	<p>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):</p> <p>(a) All direct care 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.</p> <p>The state agency Medical Assistance Administration is responsible for reviewing a sample of all personnel records to ensure that the check is indeed conducted.</p>
<input type="checkbox"/>	<p>No. Criminal history and/or background investigations are not required.</p>

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*):

<input type="checkbox"/>	<p>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):</p>
<input checked="" type="checkbox"/>	<p>No. The State does not conduct abuse registry screening. No abuse registry is available to date</p>

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

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<input type="radio"/>	No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. <i>Do not complete Items C-2-c.i – c.iii.</i>
<input checked="" type="radio"/>	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>Complete Items C-2-c.i –c.iii.</i>

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Long Term Care	Assisted Living	Each Assisted Living facility is subject to periodic review, as outlined by Health Regulation Administration -Assisted Living Facility regulation and certificate of occupancy. 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.

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 choice of furnishing in a self-governing, semi structured enriched environment. Individuals are expected to remain largely autonomous and typically are expected will require assistance in the morning with bathing and dressing, and as needed in the evenings but are expected to ambulate independently or move in a wheel chair 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 and can choose to cook their own meals and reside totally in an independent environment with some help, as needed.

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iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State’s standards address the following (*check each that applies*):

Standard	Facility Type	Facility Type	Facility Type	Facility Type
	Assisted Living			
Admission policies	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical environment	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sanitation	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff : resident ratios	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff training and qualifications	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff supervision	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resident rights	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication administration	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of restrictive interventions	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incident reporting	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provision of or arrangement for necessary health services	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:

- Staff resident ratios are addressed by the Health Regulation Administration.
- Home health agencies usually provide one direct care giver per participant. If a couple is receiving PCA services up to four hours each one direct care giver will be responsible for care of both.
- Assisted living facilities regulations that include staffing ratios will be promulgated in January 2007.

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:*

X	No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
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<input type="radio"/>	<p>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 <i>extraordinary care</i> 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-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.</p>

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:*

<input type="radio"/>	The State does not make payment to relatives/legal guardians for furnishing waiver services.
<input type="radio"/>	The State makes payment to relatives/legal guardians under <i>specific circumstances</i> 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.
<input type="radio"/>	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-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered.
<input checked="" type="radio"/>	<p>Other policy. <i>Specify:</i></p> <ul style="list-style-type: none"> • The State does allow family members who have been noted as appropriate caregivers to work for an approved agency and provide care • Care givers must complete 75 hour of training • Care givers must take 12 hours of Continuing Education courses per year

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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 on line as well as with the MAA Office. Chart indicates the requirements for the provision of each service under the Waiver. Licensure Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

The provider enrollment process is open to all willing and qualified providers. Each provider has the opportunity to enroll if they meet the approved qualified criteria (State/local and Federal criteria, e.g. District licensure requirements and requisite Code of Federal regulations for the provision of services) for provision of services for the EPD Waiver.

Providers have ready access to information regarding requirement and procedures to qualify. This can easily be done by connecting to the Internet and typing www.adrcdc.org. This site maintains all appropriate EPD Waiver provider and participant information for enrollment including contact persons. Additional information can be obtained by contacting the MAA-ODA Offices in person or by phone and staff will provide information and provider application, as needed.

PROVIDER ENROLLMENT PROCESS:

1. Provider applications are submitted to the Fiscal Intermediary ACS, who in turn scans the application and submits the document to the Office of Program Operations.

2. Program Operations reviews all provider application packets for completions of request for provision of specific provider type i.e. Nursing Home, Home Health, HMO, etc. necessary signatures and billing information

Program Operations checks the application for Professional Licensure, credentials, for all professionals who request to provide services. Information such as Certification/Registration Specialty Information i.e. Behavioral Health/Practitioners, Dental Practitioners Hospital/Facilities Pharmacy providers, Transportation providers, Health Care Facilities, Affiliations, Professional Liability Insurance Coverage, Malpractice Claims, History, Revoked or suspended licensure, DEA Numbers, Criminal History, Drug use, suspension of Medicare/Medicaid, OSHA. Sanctions from a regulatory agency etc. business ownerships.

3. The application is then sent to the Medical Assistance Administration, Office on Disabilities and Aging for review of 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
- A copy of the by-laws or similar documents regulating conduct of the provider's internal affairs

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- A copy of the business license
- A copy of Joint Commission on Accreditation of Health Care Organization’s certification
- The submission of any other documentation deemed necessary by the Department for the approval process as a Medicaid Provider Additional requirement are Quality Improvement Plan, Admission process, Code of conduct, Policies and procedures, agency complaint process.
- Final steps in the application approval process entail application review by the MAA committee. The Medical Director, the Office of the Chief Financial Officer, and Office of Quality Management.
- The Medical director checks for the credentials of the health care professionals (current), appropriateness of projected provision of services
- The Chief financial Office reviews the application for sufficient capital and funding to support provision of services. They also provide/ determine the rate structure for nursing facilities out of state.
- The Office of Quality management reviews the application for Quality Improvement plans, risk assessment/ mitigation plans, policies on safety and security, Emergency plans.
- If all Officials approve the application as submitted then the entire document is copied by ODA and retained the files. The original is sent to the Office of Program Operations where a permanent provider number is issued and notification letter of approval is mailed.
- 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 MAA 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.
- When the application is approved there is a Mandatory Provider orientation conducted by MAA for programmatic and billing services.
- The orientations by MAA consist of all policies and procedures of the EPD waiver program, review of requisite rules, including Home Health. Additionally, the provider is given a CD that contains all of the required documentation for the EPD waiver.
- A billing manual is provided during the orientation and a class is scheduled and conducted by ACS.

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Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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).

All of the waiver services are subject to the Medicaid Management Information System and the Fiscal Intermediary for the District of Columbia Associated Computer System has recently implemented a prior authorization system that requires pre-authorized approval for service provision. Total annual amounts and service provision are placed into the system. Edits authorize the approved dollar amount only. Overrides of the approved services and dollar amount cannot be performed without the written consent of the Office on Disability and Aging.

Service Specification	
Service Title:	Chore Aide
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
<p>Service Definition (Scope): Chore Aide services consist of heavy, one unit, typically one day but can be up to four days time of non medical, household remediation tasks intended to place the home environment in a clean, sanitary and safe condition. Ideally, the chore aide prepare 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 and/or Personal Care Aide can conduct light household cleaning on a more routine basis.] (One unit is considered up to 32 hours of services).</p> <p>Minimum Standards-The home care and/or home health agency and/or business must assure that each chore aide providing services to waiver Customers has successfully completed a 40-hour initial training course which meets training guidelines for Level 1 Home care workers established by the Nationally recognized Home Care University. Such training must include a component on the safe use of household chemicals (including dangerous mixtures and working with combustible agents.) Initial training must be completed prior to making a chore aids assignment to an individual’s home. Chore Aides must also complete a minimum of three (3) hours of continuing education at quarterly intervals on an annual basis. [12 hours annually]</p> <p>Chore services must include a pre- and post-cleaning inspection of the home and/or place of residence and documentation indicating that the home environment has been placed in a state of readiness for ongoing, routine housekeeping. Chore services will not be reimbursed by the State Agency unless the Agency is provided with pre-and-post-cleaning documentation.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
One hour spent performing allowable task(s). Maximum amount of service permitted under the waiver is 32 units (four days). Service is limited to one occurrence per customer. An occurrence is defined as any number of units between 1 – 32 units. 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.	

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Chore aide services are 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. Chore aide task must be performed in accordance with an individualized Services Plan [ISP] developed by supervisory personnel employed by the home care and/or home health agency and/or business. 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 on the ISP.

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	O	Individual. List types:	X	Agency. List the types of agencies:
		Chore Aide		Home Health Care
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian

Provider Qualifications *(provide the following information for each type of provider):*

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Home Health Care Agency	Agencies must be licensed to do business in the District of Columbia. DC DOH Health Regulation Administration requires the below specifics: Found in Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983 DC Municipal Regulations (DCMR) Title 22, Chapter 39 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	Staff providing Chore services must successfully complete a Homemaker or Home Health Aides Training and Certification Program. Staff providing Chore services must complete six hours of Continuing Education annually.	Agencies must have bylaws or similar documents regulating conduct internal affairs Policies and Procedures

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Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Home Health Agency	MAA Office on Disabilities and Aging verify credentials of staff initially and ten percent sampling of the staff credentials annually		Agencies reviewed upon application to MAA and on 12 month monitoring site visit	
	MAA Office on Program Operations verify the all Home Health Care Agency licensure		Agencies reviewed upon application to MAA and at 18-24 months.	
Service Delivery Method				
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>		X	Provider managed In home Support

Service Specification	
Service Title:	Respite Care Service
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
X	Service is included in approved waiver. There is no change in service specifications.
O	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Respite Care Service is defined as the provision of companionship, supervision and/or assistance with Activities of Daily Living (ADL's) for waiver customers in their home or place of permanent residence in the temporary absence of the primary caregiver(s). Respite services encompass the range of tasks associated with the personal Care Aide (PCA) role. Meal Preparation, light house keeping, grooming assistance with ADL and IADL See: State Plan Standards for PCA services. In addition, to those specified roles, monitoring, companionship and observation are allowable tasks for respite care providers.</p> <p>Minimum Standards -The home care and/or home health agency and/or business must be developed and utilize an initial intake protocol that assesses the customer's respite needs and the appropriate level of caregiver required to meet the need. 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 employed by the home care and/or home health agency and/or business. Should the customer have a need for an RN respite care provider, the case manager must be notified immediately. A copy of the initial intake protocol must be on file with the home care and/or home health agency and/or business. All records must be maintained on file for a period of not less than six (6) years.</p> <p>In conducting the intake assessment, the Registered Nurse (RN) (a) must establish a written emergency notification plan for each customer receiving respite care services; and must document that the emergency notification requirement must be kept on file with the home care and/or home health agency and/or business for a period of not less than six (6) years</p> <p>No respite caregiver may leave the home or place of residence of the customer during period of time which respite care is being provided unless the home care and/or home health agency and/or business that is responsible for providing the services replaces such caregiver prior to the caregiver removing himself from the customer's home or primary place of residence.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

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One to twenty-four hours spent performing allowable tasks. Each waiver customer may receive a maximum of 480 non-continuous hour of respite care per year. Payment will not be made to a provider who is the waiver recipient's (a) spouse or parent or, if minor recipient, legal guardian.

Requirements for respite service(s) in excess of established limits must be approved or denied on a case by case basis by the State Agency prior to the provision of such service(s).

In order to be eligible for respite care services, the waiver customer must (a) require continual supervision in order to live in his/her own home (or the home of the primary care giver with whom he or she resides), and (b) require a substitute care giver while his/her primary care giver is in need of relief or otherwise unavailable; and/or (c) the customer must be unable to perform Activities of Daily Living (ADL's) without assistance.

No person may receive PCA services other than those provided by the respite caregiver during the period of time during which respite care is being provided.

Respite care services may not be provided to customers who have no primary caregiver who is responsible for the provision of the customer's care on an ongoing basis.

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Home Health care agencies, Health care agencies
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian

Provider Qualifications *(provide the following information for each type of provider):*

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Home Health Care Agency	Agencies must be licensed to do business in the District of Columbia DC DOH Health Regulation Administration requires: DCMR Home Care Agencies Title 22, Chapter 39 .” 3900.5 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	Staff providing respite care services must be certified as home health aides or a personal care aide Staff providing respite care must complete twelve hours [12] of continuing education annually Staff providing respite care services must be certified as home health aides or a personal care aides. Staff providing respite care must complete twelve hours [12] of continuing education annually	Agencies are guided according to By-Laws of Agencies for conduct Policies and Procedures and QA plan similar documents govern conduct and guide the operations of the agency

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Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Home Health Agency	MAA Office on Disabilities and Aging verify credentials of staff initially and ten percent of the staff credentials annually	Agencies reviewed upon application to MAA and on 12 month monitoring site visit	
	Office on Program Operations verify the all Home Health Care Agency licensure	Agencies reviewed upon application to MAA and at 18-24 months.	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Provider managed In Home Support

Service Specification	
Service Title:	Case Management Service
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Case Management service is designed for ensuring that the participant gains access to needed linkages in the community. Case Managers obtain home and community based Medicaid Waiver services for participants by identifying waiver services, community supports as well as State plan services.</p> <p>Case management services are participant focused assisting individuals in remaining in the community as they age in place. They do not replace family systems, and/or other community services but augment the participant's natural support. Case managers, family supports, and interdisciplinary providers are accountable in developing the Individual services plan.</p> <p>Case management services assist in provision of coordination of all Waiver services provided to customers so that services are delivered in a safe, timely and cost-efficient manner. Including but not limited to the following:</p> <ul style="list-style-type: none"> • Activities associates with the customer to access waiver services. These activities include obtainment of a level of care determination and financial eligibility documentation • Completion the comprehensive customer assessment, • Development of the comprehensive ISP utilizing interdisciplinary team members, customer and/or designee, family members and/or legal guardian, 	

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- Presentation of the completed ISP to customer and/or designee for acceptance of services
- Submission of the ISP for Agency approval; implementation of services.
- Assisting the participants select service providers
- Assisting participant with securing necessary physician orders when required for the initiation of and service providers
- Assisting participant with initiating services provisions
- Ensuring proper implementation of waiver services
- Providing information about non-Medicaid programs and services for which the participant might be eligible, referring the participant to the proper services as necessary, and providing assistance to the participant in gaining public benefits and linkages to the community resources
- Coordination of multiple services and /or providers
- On-going monitoring of the implementation of ISP services to ensure that customers are receiving ordered services and to ensure quality of care and services provision, including identification and resolution of problems with the provider of Waiver services, providing telephone reassurances and friendly visiting to participants as part of the case management program.
- Providing supportive counseling to participant and family as appropriate
- On-going assessment of customer appropriateness for participation in the waiver
- Ensuring participant obtains annual level of care certification and ensuring that such information is communicated to the State agency in a timely manner
- Ensuring the Medicaid/Medicaid Waiver re-certifications are complete before the end of the customer’s certification period
- Maintaining necessary records necessary to provide supportive documentation of all case management services provided. All records must be maintained in a manner consistent with customer privacy and confidentiality
- Ensuring ISP’s include a risk assessment and identified risk mitigation plan
- Ensuring that each participant had an emergency plan for back-up in place.
- Social service agencies that provide case management services do not provide direct Home Health or Personal Care Aide services and do not provide any other Medicaid service to the participants. The primary role of the Case Manager is to ensure the linkages to the community and in effect arrange for needed service through the Home Health care agencies. The community based agencies are employers of the Case Managers and the Case managers must maintain at least the minimum standards that are required by rule of the Home Health Agency Case Managers.
- The community–based agencies that provide case management services do not provide direct Home Health or Personal Care Aide services and do not provide any other medical service to the participants. The community based agencies that are employers of the Case Managers must meet the same qualifications as Home Health Care Agencies and the minimum standards that are required of Home Health Agency Case Managers.

Minimum standards-

- Each case manager/ provider must be an employee of a home health care agency, and/or social service agency, and/or other community-based organization hereafter known as the provider, licensed to

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conduct business in the District of Columbia as well as licensed to conduct business by HRA

- Each case management provider must demonstrate a service history and current capacity to assist customers in accessing services provided through the D.C. Office on Aging and/or agencies serving individuals with physical disabilities
- Each case management provider agency must demonstrate a comprehensive knowledge and understanding of the District of Columbia Medical Assistance Administration Program including knowledge of limitation on State Plan services and an understanding of the relationship between State Plan and waiver services where applicable.
- Each case management service provider must establish and implement a process by which customer satisfaction demonstrates to the case management services provider agency that the participant has been informed of his/her freedom of choice rights, and that the customer and/or the customer’s legal guardian have 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
- Each case management service is responsible for conducting a comprehensive assessment of the customer using the assessment must be conducted within forty-eight (48) hours of receiving the waiver request and prior to the development of the ISP. The written assessment and ISP must be completed within seven (7) working days of conducting the assessment.
- Each case management services provider may include family members, friends of participant, and any other appropriate individual(s) in the initial customer assessment and the development and implementation of the approved ISP, as per participant request and/or as appropriate.
- Each case management service provider is responsible for conducting a comprehensive assessment of the customer using the assessment tool that is provided by the State Agency. The comprehensive assessment may include family members, friends of the family as requested by the participant.
- The development of the ISP must be an interdisciplinary team activity. The interdisciplinary team must at a minimum consist of the following professionals: (a) case manager with the requisite credentials and/or experience (see above), and (b) Registered Nurse (RN), duly licensed in the District of Columbia in accordance with the District of Columbia Health Occupations Revision Act of 1986 and all amendments thereto. It is the responsibility of the case management service provider agency and/or business to ensure that other professional disciplines are a part of the ISP development process on an as needed basis. The update of the ISP is the responsibility of the case manager and must be done. Signature of the team members will be required on the ISP as indication of team approval.
- It is the responsibility of the case management service provider to ensure that the ISP is provided to the State Agency for approval of services. The State Agency will approve or disapprove the ISP within seven (7) working days of its receipt.
- The case manager must ensure that the participant is given free choice of all qualified Medicaid providers of each service included in his/her written ISP.
- Each case management service provider must provide the participant, family members, caretakers, 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.

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- Each case management service provider must provide participants, family members, legal guardians and/or caretakers with agency procedures for protecting confidentiality, for reviewing progress against the ISP, participant rights, and other matters germane to the participant's decision to accept services.
- All case management service providers must demonstrate comprehensive knowledge of and actual experience with assisting participant to access all types of community-based programs including legal services, rent assistance programs, food and nutrition programs (including food stamps), cash benefit programs (including SSI) and energy assistance programs.
- As part of on-going monitoring of the participant, each case management service provider is required to make an in-home visit to the customer at a minimum of at least once per month (within 30 days) and more frequently as required by the customer's condition. Supplemental telephone contacts may be made as required by the individual needs of the customer.
- Case management service providers must provide services in accordance with provider guidelines and any amendments developed by the State Agency.
- Each case management service provider who provides direct case management services is required assist the customer in accessing all necessary services that are available to the customer and that are necessary to maintaining the customer in the community whether they are Medicaid (State Plan) services, Medicaid (Waiver) services and/or non-Medicaid financed services.
- Each case management service provider agency and/or business 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. In addition, each case management service provider and/or business must maintain, follow, and continually update a training and supervision program to make sure case management staff who are responsible for the provision of direct case management services are fully trained and familiar with State Agency policy and procedures.
- Each case management service provider agency and/or business 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. In addition, each case management service provider and/or business must maintain, follow, and continually update a training and supervision program to make sure case management staff who are responsible for the provision of direct case management services are fully trained and familiar with State Agency policy and procedures.
- As part of on-going monitoring of the customer, each case management service provider is required to make an in-home visit to the customer at a minimum of at least once per month

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(within 30 days) and more frequently as required by the customer’s condition. Supplemental telephone contacts may be made as required by the individual needs of the participant.

- Each case management service provider must develop and implement a plan to ensure against duplication of services being provided to the participant..

Each case management service provider who provides direct case management services is responsible for conducting a comprehensive reassessment of the participant **annually** using the assessment tool that is provided by the State Agency. However, if the Provider implements both Direct Care as well as Case Management each participant must sign that the provider agency gives him/her a choice of Case Managers.

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

All activities associated with general oversight of the participant and all services being provided to the customer. Included in this service unit are the following activities:

- Monthly (within 30 days) in-home visits;
- Communicating and coordinating with service providers as needed;
- Documentation of all case management activities;
- Assisting participant to obtain level of care re-determination and Medicaid recertification as needed;
- Communication with State agency personnel as needed;
- All other activities related to the efficient administration of the waiver and maintaining the participant in the home. Case management service providers may not receive Medicaid reimbursement for case management services to ineligible individuals.
- Annual reassessment all activities associated with reassessment of the participant in order to continue waiver and other needed services

Service limitation- Customer and/or authorized representatives may elect to receive or not receive any waiver services by signing the “Beneficiary Freedom of Choice Form.”

Case management service providers may not provide medical, financial, or legal services (except for referral to qualified individuals, agencies or program).

Case management service providers may not receive Medicaid reimbursement for case management services to non-Medicaid participant.

Case Managers are discouraged from managing client or customer services provided by the same agency that employs the case manager that also provides direct care services (such as PCA services).

Provider Specifications

Provider Category(s) <i>(check one or both):</i>		Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Home Health agency, Social service agency , Community-based organizations (all held to same state standards of operations)

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Specify whether the service may be provided by (<i>check each that applies</i>):N/A	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License (<i>specify</i>)	Certificate (<i>specify</i>)	Other Standard (<i>specify</i>)
Home Health Care Agencies	<p>Agencies must be licensed to conduct business in the District of Columbia.</p> <p>Staff providing Case Management must have current appropriate licensure, and have a Masters and one year of experience with the population degree in Social work, Psychology, Counseling, Rehabilitation, Nursing, Gerontology, or sociology</p> <p>Bachelors degree and the above current licensure and 2 years of experience with the population.</p> <p>Registered Nurse can [RN] can have an Associate Degree and 3 years of experience, And current license</p> <p>Health Regulation Administration requires: DCMR Home Care Agencies Title 22, Chapter 39.” 3900.5</p> <p>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</p>		<p>By-laws or similar documents regulating conduct of provider’s internal affairs</p> <p>Policies and Procedures and QA Plan</p>

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<p>Social Service Agencies,</p>	<p>Licensed to conduct business in the District</p> <p>Staff providing Case Management must have current appropriate licensure, and have a Masters and one year of experience with the population degree in Social work, Psychology, Counseling, Rehabilitation, Nursing, Gerontology, or sociology</p> <p>Bachelors degree and the above current licensure and 2 years of experience with the population.</p> <p>Registered Nurse can [RN] can have an Associate Degree and 3 years of experience.</p> <p>Health Regulation Administration requires:</p> <p>DCMR Home Care Agencies Title 22, Chapter 39 .”</p> <p>Waiver rules “Home and Community-Based Waiver Services for Persons who are Elderly and Individuals with Physical Disabilities”</p> <p>DC Municipal Regulations (DCMR) Title 29, Chapter 42</p>		<p>By-laws or similar documents regulating conduct of providers internal affairs</p> <p>Policies and procedure and QA Plan</p>
<p>Community-based Organizations</p>	<p>Staff providing Case Management must have current appropriate licensure,</p>		<p>By-laws or similar documents regulating conduct or providers’ internal affairs</p> <p>Policies and procedure and QA Plan</p>

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	<p>and have a Masters and one year of experience with the population A degree in Social work, Psychology, Counseling, Rehabilitation, Nursing, Gerontology, or sociology</p> <p>Bachelors degree and the above current licensure and 2 years of experience with the population.</p> <p>Registered Nurse [RN] can have an Associate Degree and 3 years of experience.</p> <p>Health Regulation Administration requires: DCMR Home Care Agencies Title 22, Chapter 39 .”</p> <p>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</p>		
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Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Care Agency	MAA Office on Disabilities and Aging MAA Office on Program Operations	Agencies reviewed upon application to MAA and on 12 month monitoring site visit Agencies reviewed upon application to MAA and at 18-24 months.

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Social Service Agencies	MAA Office on Disabilities and Aging	Agencies reviewed upon application to MAA and on 12 month monitoring site visit
	MAA Office on Program Operations	Agencies reviewed upon application to MAA and at 18-24 months.
Community-based Organizations	MAA Office on Disabilities and Aging	Agencies reviewed upon application to MAA and on 12 month monitoring site visit
	MAA Office on Program Operations	Agencies reviewed upon application to MAA and at 18-24 months.

Service Delivery Method Agencies reviewed upon application to MAA and at 18-24 months.

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Elderly and Persons with Disability Agency In-Home Support	<input checked="" type="checkbox"/>	Provider managed
	<input type="checkbox"/>		<input type="checkbox"/>	

Service Title: **Assisted Living Service**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Services to meet the customer’s needs as outlined in the written Individualized Service Plan (ISP) agreement between the resident and the facility, to meet unscheduled care needs, and to provide emergency services 24 hours a day.

Services provided by an assisted living facility are provided directly or under contract in a 24-hour living arrangement, licensed, personal care home. An assisted living residence is a program, which combines housing, health, and supportive services for the support of residents.

Assisted Living Services – hands-on care provided in an assisted living residence, of both a supportive and health –related nature, specific to the needs of an older person or a physically handicapped individual.

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

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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. One hour spent performing the allowable task(s). Maximum amount of service – definition of an occurrence and occurrence per customer. Services shall be:

Personal Care – those basic and ancillary services that enable an individual in need of in-home care to live in the individual’s home and community rather than in an institution and to carry out functions of daily living, self-care and mobility.

Intermittent skilled nursing – consists of those services that must, under State law, be provided by a licensed registered or practical nurse, on a periodic basis. Care may be provided: (1) up to 28 hours a week when combined with home health aide services as long as the services are not received more than three days per week; (2) up to 35 hours a week when combined with home health aide services and the need is documented, as long as the services are not received more than four days per week; or (3) up to seven days when combined with home health aide services if the need is documented and the services are received temporarily, usually up to 21 days.

Medicaid Assisted Living service cannot provide housing or meals. Payment will not be made for 24 hour skilled care or supervision, or room and board, items of comfort or convenience, costs of the facility maintenance, upkeep and improvement.

Each facility providing Assisted Living shall be licensed by the District of Columbia and comply with the requirements set forth in the Assisted Living Residence Regulatory Act of 2000.

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.

Staff shall also comply with the requirements set forth in the District of Columbia Health Occupations Revisions Act of 1985.

Provider Specifications

Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:		Agency. List the types of agencies:
	Assisted Living			
	Facility			

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

	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Assisted Living Facility	Facility must be licensed by the District of Columbia Staff RN.LPN must maintain current State license	Copies of current license and certification of staff, Personal Care Aides, Medication Technician, Homemaker	Be in compliance with Assisted Living Resident Regulatory Act of 2000

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	Health Regulation Administration Home Care Agencies DC Municipal Regulations (DCMR) Title 22, Chapter 39 .” 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		
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Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Assisted Living Facility	MAA Office on Disabilities and Aging	Agencies reviewed upon application to MAA and on 12 month monitoring site visit
	DC DOH Health Regulation Administration	Upon opening of the facility and as needed and every three years

Service Delivery Method

Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Assisted Living Residence		
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Service Specification

Service Title: **Homemaker Service**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Services consisting of general household activities (meal preparation 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.

Minimum Standards

- All persons performing homemaker services must: (a) complete a 75-hour initial training course and hold a Home Health Aide Certification consistent with the requirements of Medicare/Medicaid. In addition, homemakers must successfully complete initial CPR training and annual recertification. Initial training (and CPR certification) must be successfully completed prior to the provision of services. Three (3) hours of continuing education must be completed at quarterly intervals on an annual basis.
- Homemaker services must include: (a) an initial assessment and (b) development of an Individualized Service Plan (ISP). The ISP must address the specific homemaker needs of the customer and provide a detailed plan for meeting the identified homemaker needs of the customer. The homemaker staff person must provide service(s) consistent with the ISP developed by the case manager. A copy of the ISP must be kept in the following locations: (a) customer home; (b) case management provider; and (c) home care and/or home health agency and/or business.
- Homemaker services include the following tasks: grocery shopping (from prepared list), meal preparation, general household cleaning such as: cleaning bathrooms, vacuuming, dusting, mopping floors, sweeping floors, bed making, linen changing, wiping appliances, washing and ironing clothes, running errands for customers that are necessary to maintain the customer in the home (e.g. picking up medicine or mailing payments for utilities), and providing escort services to and from medical appointments.

No limits, but must be based upon primary caregiver or homemaker being temporarily absent. Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Homemaker services may be provided only in cases where neither the individual nor anyone

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else in the household is able to provide the service or pay for the provision of the service. Payment will not be made to a provider who is the waiver recipient's (a) spouse or (b) parent or, if minor recipient, legal guardian.

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Home Health Care
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative/Legal Guardian

Provider Qualifications *(provide the following information for each type of provider):*

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Home Health Agency	Agency Licensed for business in DC Health Regulation Administration Home Care Agencies DC Municipal Regulations (DCMR) Title 22, Chapter 39 .” 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	Staff need Home Health Aide/Homemaker certificate Staff of Homemaker service providers require twelve hours [12] Continuing Education	By-Laws Policies and Procedures Criminal background check

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Care Agency	Office on Disabilities and Aging	Agencies reviewed upon application to MAA and on 12 month monitoring site visit
	Office of Program Operations	Agencies reviewed upon application to MAA and at 18-24 months.

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Certified Home Office	Health Regulation Administration	Annually		
Service Delivery Method				
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>		X	Provider managed

Service Specification	
Service Title:	Personal Care Aide Services
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	

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PCA Definition ---- Personal Care Aide – a person who has successfully completed the state or District of Columbia established training program and meets the competency evaluation requirements. Tasks include assistance with activities of daily living and instrumental activities of daily living.

PCA Services – 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. This initial intake assessment must be conducted by a Registered Nurse (RN) who is (a) duly licensed to practice in the District of Columbia; and (b) is employed by the home care and/or home health agency and/or business.

- In conducting the intake assessment, the Registered Nurse (RN) (a) must establish a written emergency notification plan for each customer receiving respite care services; and (b) must document that the emergency plan has been reviewed with the individual staff person who will provide the respite care. All documentation related to this emergency notification requirement must be kept on file with the home care and/or home health agency and/or business for a period of not less than six (6) years.
- No respite caregiver may leave the home or place of residence of the customer during the period of time during which respite care is being provided unless the home care and/or home health agency and/or business that is responsible for providing the services replaces such caregiver **prior to** the caregiver removing himself or herself from the customer’s home or primary place of residence.

Allowable Tasks: Personal Care Aide (PCA) services include the following tasks: bathing, skin care, oral hygiene, dressing, ambulating, making bed, feeding, toileting, exercise program, reminding to take medications, light laundry, light housekeeping, grocery shopping, meal preparation, and accompanying customer to medical appointments.

Minimum Standards:

- All persons performing PCA services must complete a 75-hour initial training course and hold a Home Health Aide Certification consistent with the requirements of Medicare/Medicaid. In addition, PCA’s must successfully complete initial CPR training and annual recertification. Initial training (and CPR certification) must be successfully completed prior to the provision of services. Three (3) hours of continuing education must be completed at quarterly intervals on an annual basis.
- It is the responsibility of the direct care provider to ensure that the necessary and appropriate orders (see State Plan) for PCA services (e.g. certification and recertification of the Physician's Plan of Care) are properly obtained and submitted to the State Agency with the ISP, and at other required intervals. Certification is required for the initiation of the service and services must be recertified according to the State Plan. Each certification/recertification must be signed by the physician within 30 days of the start date of the certification period.
- All existing approved State Plan service definitions, provider qualifications and standards, provider reimbursement rates and unit of service definitions for PCA services, and other service limitations, restrictions and requirements are applicable.

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

- One hour spent performing allowable task(s). This waiver lifts any State Plan restrictions on the number of allowable personal care aide hours as long as the PCA hours in excess of State Plan

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limitations are provided in accordance with an approved ISP and are cost effective.

- Payment will not be made to a provider who is the waiver recipient’s (a) spouse or (b) parent or, if minor recipient, legal guardian.

Provider Specifications

Provider Category(s) <i>(check one or both):</i>		Individual. List types:	X	Agency. List the types of agencies:
				Home Health care agencies
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications *(provide the following information for each type of provider):*

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Home Health Care Agencies	Agencies must be licensed to provide Home Health Services, and meet Medicaid Provider Application requirements in the District of Columbia DC DOH Health Regulation Administration Home Care Agencies DC Municipal Regulations (DCMR) Title 22, Chapter 39 .” 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	Current certification of staff (PCA) as issued by a n approved school for PCA Continuing education of 12 hours must be completed on an annual basis.	By-Laws Policies and Procedures

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	<p>PROVIDER ENROLLMENT PROCESS:</p> <p>1. Provider applications are submitted to the Fiscal Intermediary ACS, who in turn scans the application and submits the document to the Office of Program Operations.</p> <p>2. Program Operations reviews all provider application packets for completions of request for provision of specific provider type i.e. Nursing Home, Home Health, HMO, etc. necessary signatures and billing information</p> <p>Program Operations checks the application for Professional Licensure, credentials, for all professionals who request to provide services. Information such as</p> <p>Certification/Registration Specialty Information i.e. Behavioral Health/Practitioners, Dental Practitioners , Hospital/Facilities Pharmacy providers Transportation providers, Health Care Facilities Affiliations Professional Liability Insurance Coverage, Malpractice Claims, History,</p>		
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	<p>Revoked or suspended licensure, DEA Numbers, Criminal History, Drug use, suspension of Medicare/Medicaid, OSHA. Sanctions from a regulatory agency etc. business ownerships.</p> <p>3. The application is then sent to the Medical Assistance Administration, Office on Disabilities and Aging for review of the following:</p> <ul style="list-style-type: none"> • A description of ownership and a list of major owners • A list of Board members and their affiliation: • 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 		
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	<ul style="list-style-type: none"> • A completed copy of the basic organizational documents of the provider, including any organizational chart and current articles of the incorporation • A copy of the by-laws or similar documents regulating conduct of the provider's internal affairs • A copy of the business license • A copy of Joint Commission on Accreditation of Health Care Organization's certification • The submission of any other documentation deemed necessary by the Department for the approval process as a Medicaid Provider Additional requirements are Quality Improvement Plan, Admission process, Code of conduct, Policies and procedures, agency complaint 		
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	<p>process .</p> <ul style="list-style-type: none"> • Final steps in the application approval process entails application review by the MAA committee. The Medical Director, the Office of the Chief Financial Officer, and Office of Quality Management. • The Medical director checks for the credentials of the health care professionals (current), appropriateness of projected provision of services • The Chief financial Office reviews the application for sufficient capital and funding to support provision of services. They also provide/ determine the rate structure for nursing facilities out of state. • The Office of Quality management reviews the application for Quality 		
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	<p>Improvement plans, risk assessment/ mitigation plans, policies on safety and security, Emergency plans.</p> <ul style="list-style-type: none"> • If all Officials approve the application as submitted then the entire document is copied by ODA and retained the files. The original is sent to the Office of Program Operations where a permanent provider number is issued and notification letter of approval is mailed. • 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 MAA within the specified timeframe, the application is returned to the 		
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	<p>provider as it is assumed he/she is no longer interested in providing services for the District of Columbia. However, he/she is given the opportunity to submit another application at their leisure.</p> <ul style="list-style-type: none"> • When the application is approved there is a Mandatory Provider orientation conducted by MAA for programmatic and billing services. • The orientation by MAA consist of all policies and procedures of the EPD waiver program, review of requisite rules, including Home Health. Additionally, the provider is given a CD that contains all of the required documentation for the EPD waiver. • A billing manual is provided during the orientation and a 		
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	class is scheduled and conducted by ACS.		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	Office on Disabilities and Aging	Agencies reviewed upon application to MAA and on 12 month monitoring site visit
	Office on Program Operations	Agencies reviewed upon application to MAA and at 18-24 months.

Service Delivery Method

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	In-Home Support (but not limited to)	<input checked="" type="checkbox"/>	Provider managed

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Service Specification	
Service Title:	Personal Emergency Response Services (PERS)
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>An electronic system that summons assistance from a friend, relative or an ambulance). Each system is comprised of three basic elements (a) a small radio transmitted (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. No PERS will be provided for persons who are unable to understand and demonstrate proper use of the system. No PERS will be provided to persons who live with a person who assumes responsibility for providing care (to the waiver customer) and the waiver customer is not left alone for significant periods of time.</p> <ul style="list-style-type: none"> • In-home installation of all equipment necessary to make the system fully operational (including batteries); • Customer (family) instruction on usage, maintenance, and emergency protocol; • Equipment maintenance (both in-home and response center); • 24-hours per day, 7-days per week response center monitoring; • Equipment testing, monitoring and maintenance (both in-home and response center equipment); • Monthly system checks; and • Documentation of all services provided, customer contacts, equipment checks and equipment servicing. 	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
<p>One to twenty-four hours spent performing allowable tasks. Each waiver customer may receive a maximum of :</p> <ul style="list-style-type: none"> • 480 non-continuous hours of respite care per year. Payment will not be made to a provider who is the waiver recipient’s (a) spouse or (b) parent or, if minor recipient, legal guardian. • No PERS will be provided for persons who are unable to understand and demonstrate proper use of the system. • No PERS will be provided to persons who live with a person who assumes responsibility for providing care (to the waiver customer) and the waiver customer is not left alone for significant periods of time. • PERS response center support must be provided on a 24-hours per day, 7-days per week basis. • Emergency equipment repair service must be available to the customer on a 24-hours per day, 7-days per week basis. • The PERS provider must allow the customer to designate respondent(s) who will respond to 	

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emergency calls. Respondents may be relatives, friends, neighbors or medical personnel.

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
	Agency for PERS		Emergency Services	
	Emergency			

Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person N/A	<input type="checkbox"/>	Relative/Legal Guardian N/A
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Provider Qualifications *(provide the following information for each type of provider):*

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Personal Emergency Response System (PERS)	Companies incorporated for the purpose of selling Personal Emergency Response Systems (PERS)	N/A	By-laws or similar Policies and Procedures

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Emergency Agency	MAA Office of Program Operation	Agencies reviewed upon application to MAA and at 18-24 months.
	MAA Office on Disabilities and Aging	Agencies reviewed upon application to MAA and on 12 month monitoring site visit

Service Delivery Method

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	In-Home Support	<input checked="" type="checkbox"/>	Provider managed
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Service Specification

Service Title: Environmental Accessibility Adaptations (EAA)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Those physical adaptations to the home (required by the ISP) which are necessary to ensure the health, welfare and safety of the individual to function with greater independence in the home, and without which, the individual would require institutionalization.

Allowable Modifications: Environmental Accessibility Adaptations (EAA) include the following:

- Installation of ramps and stair climbers
- Widening of doorways; Installation of ramps as necessary to allow safe entrance and exit from a primary residence; Modification of bathroom facilities to accommodate safe use by the customer; and,
- Installation of specialized electric and plumbing systems necessary to accommodate medical equipment and supplies;

Limitations: Adaptations or improvements to the home which are of general home repair. No EAA services will be approved or reimbursed for a customer who qualifies for the Handicap Accessibility Improvement Program (HAIP) administered by the Department of Housing and Community Development or can demonstrate the HAIP program has been unable to assist. It is the responsibility of the case management service to assist all eligible customers in gaining access to the HAIP program and provide documentation thereof to the State agency.

All necessary service(s) that exceed the maximum provided by the Department of Housing and Community Development are subject to prior authorization by the State Agency.

In the case of rental property and/or leased property, no EAA services will be approved or reimbursed unless the rental and/or lease agreement (and all other relevant documents) are thoroughly examined (by the case manager) to determine whether such services are prohibited or allowed with conditions: (a) the rental and/or lease agreement is thoroughly examined to determine that such services are not the responsibility of the property owner and/or manager; and, (b) without a signed release from the management of such property.

- The case management service **must** ensure that a home assessment is conducted (by a licensed physician or a licensed physical therapist) prior to ordering EAA service(s) on the ISP. The (signed) home assessment form **must** be submitted to the State Agency with the ISP.
- Prior to initiating EAA services, the case management service **must** obtain three bids that include a Housing Inspector request for permit. The bids must also substantiate that the home is in a condition that is structurally sound to meet District code and can accommodate each ordered service(s) and any stipulation(s) or limitation(s) or recommendation(s) on how the service(s) should be implemented.
- After receiving the bids including Housing Inspector permit, the case management service must secure three bids (from among licensed contractors for necessary services that have been

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approved by the State Agency. All bids submitted, in order to be considered acceptable, must be by licensed and bonded contractors and include any stipulation(s), limitation(s) or recommendation(s) consistent with District Housing Inspector.

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

Maximum allowable costs per customer is \$10,000. All service(s) required are subject to approval or denial by the State Agency prior to the provision of such service(s). Repairs require prior authorization by the State Agency. This is a one time service.

Provider Specifications

Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
	Construction company		Companies licensed to do business in the state in which they are incorporated and licensed to do business in the District of Columbia	
	Provider of Building Services			
	Contractor			

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

	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Environmental Accessibility Adaptation	Agency Licenses Contractors Building contractors licensed in the District of Columbia		All required building and construction permits and licenses required under District of Columbia

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Construction Co.	Office on Disabilities and Aging	Agencies reviewed upon application to MAA and on 12 month monitoring site visit
	Office on Program Operations	Agencies reviewed upon application to MAA and at 18-24 months.

Service Delivery Method

Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/>	Construction Services to participants as approved in home	<input type="checkbox"/>	Provider managed

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Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*check each that applies*).

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; and, (f) how participants are notified of the amount of the limit.

<input type="checkbox"/>	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. <i>Furnish the information specified above.</i>
<input type="checkbox"/>	Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. <i>Furnish the information specified above.</i>
<input type="checkbox"/>	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. <i>Furnish the information specified above.</i>
<input type="checkbox"/>	Other Type of Limit. The State employs another type of limit. <i>Describe the limit and furnish the information specified above.</i>
<input checked="" type="checkbox"/>	Not applicable. The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

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Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:

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 (*check each that applies*):

<input type="checkbox"/>	Registered nurse, licensed to practice in the State may be part of the interdisciplinary team
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O) May be part of the interdisciplinary team
<input checked="" type="checkbox"/>	Case Manager (qualifications specified in Appendix C-3) Ultimate responsibility for development of the Individual services plan.
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	Other (<i>specify the individuals and their qualifications</i>):
<input type="checkbox"/>	

b. Service Plan Development Safeguards. *Select one:*

<input checked="" type="checkbox"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other direct waiver services to the participant.
<input type="checkbox"/>	

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The District of Columbia Municipal Regulations Chapter 42 of Title 29 indicates that the case manager shall not provide medical, financial, legal, or other services or advice for which they are not qualified or licensed to perform (except for referral to qualified individuals, agencies, or programs.) More specifically, the case manager shall document a complete synopsis of the participant’s care and outcomes of the information should include: utilization of services; communication with other providers regarding the participant’s goals; progress and outcomes; identification and resolution of problems; and referrals or linkages to the community resources. ODA encourages an Interdisciplinary team approach. (Physician, nurse, family member, case manager) to develop both the Individual service plan and the plan of care. This provides more checks and balances for case managers.

Signed Individual Service Plans, Client Health History are sent to the DOH Medical Assistance Administration, Office on Disabilities and Aging for review and approval.

- Case Managers do **not** provide direct care services. Case managers are allowed to carry a maximum of 45 persons per case load.
- The minimum schedule under these reviews will occur:
 - 1) updated every 12 months
 - 2) In addition to every 12 months, the plan of care will be reviewed every quarter and/or on an as needed basis whenever a change in the customer’s needs indicate. ISP must be signed by members of the interdisciplinary team.
- The Case management provider may not assign, any immediate family or legal authority representative of a recipient as a case manager
- A case manager may not provide any other Medicaid Waiver services to participants for whom the agency provides case management services
- The Provider must maintain a current participant roster per Case Manager. The information must be available upon request to the Medical Assistance Administration.
- MAA does not encourage the practice of a Case Managers working for more than one agency. In the event a Case Manager works for more than one contracting or employing agency the combined case load must not exceed forty-five (45)
- Failure of an agency to adhere to the policy will result in immediate moratorium until case loads are adjusted to forty-five (45)

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.

Participant can determine with Case Managers, and family members (as designated by the participant) what services they choose to receive; The participant maintains the authority to identify family members or others who may assist with supports.

The case manager identifies the information and supports that are available to the participant to actively engage in their care needs and the process. Referrals and linkages to community resources. (see case managers responsibilities in D-2). DCMR Chapter 42 Title 29 indicates that Each case manager who provides direct case management services

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is required to assist the participant in accessing all necessary services that are available to the participant and that are necessary to maintaining the participant in the community whether they are Medicaid (State Plan) services, Medicaid (waiver) services, or non-Medicaid financed services.

The Beneficiary Freedom of choice document indicates that the participant chose to make the decision as outlined. Once decisions are made the provision of service is identified by the signature of the participant as well as a witness, if necessary.

- 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):

- (a). The participant –centered service plan is developed by the participant and family members, if the participant chooses. The Case Manager is responsible for the development of the plan. However, she should assemble an interdisciplinary team for the plan development.
- (b). The following types of assessments are conducted:
 Social, physical, environmental and health and welfare
 Assessments are offered. The participants’ health care needs are assessed in the health and welfare component and are noted in the participant’s health history. Preferences are threaded throughout all of the assessments as listed.
- (c) Prior to beginning of direct care implementation all participants are sent a letter that outlines the types of services approved, the frequency and duration of the service/s and the providers of those services. The participant is also contacted by a case manager and participant receives information on the range of services and discusses choices of services. Once choices are made potential implementation dates are discussed and selections are made.
- (d) The plan is developed jointly by the participant with the case manager relying on clinical, environmental and social assessment

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information with participant’s shared goals, health care and other needs and preferences.

(e) The case manager assists the participant in making decisions on what services may best meet the needs and goals of the participant.

(f) The Case Manager both helps with the implementation of the plan and services as well as monitors the plan of care and supports needed and utilized. The participant teams with the Case Manager to review progress and decide the types of services that will be needed and or best utilized. Should the person require other Medicaid services such as for a hospitalization or rehabilitation the participant’s team reviews care coordination and progress towards goals.

(g) The plan is reviewed by the Case manager, the participant and family members as outlined quarterly basis and reassessed, with a new or revised plan on a semi-annual basis. All waiver participants must re-certify annually. Should goals or needs change the ISP will reflect the necessary changes as needed when needed.

To access waiver and other needed services the following are developed or attained. These activities include:

- obtainment of a level of care determination;
- completion of the comprehensive participant assessment;

e. Medicaid waiver services are selected by the participant and coordinated through the case manager who assist the participant

- development of the comprehensive ISP utilizing interdisciplinary team members, participant and/or designee, family members and /or legal guardian;
- presentation of the completed ISP to customer and/or designee for acceptance of services;
- submission of the ISP for Agency approval;
- assisting the participant to select Medicaid service providers;
- ensuring proper implementation of services.
- ensuring the family and case manager has developed an emergency contingency plan when agency services for unforeseen reasons are unavailable or fail. Case Managers develop the plan in conjunction with participant as well as family.

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D-1-d. items (a) through (g) are addressed in the District of Columbia Municipal Regulations, Chapter 42, Title 29

Case management services are ongoing activities and shall include the following:

- Conducting direct observation of the recipient;
- Conducting financial and functional eligibility screening, contact, or interaction with the recipient’s authorized representative;
- Conducting a comprehensive assessment of the recipient’s medical, social and functional status to include obtainment of level or care determination and financial eligibility documentation
- Case managers are responsible for determining and developing the participant’s ISP in collaboration with an interdisciplinary team of professionals and including the recipient or authorized representative, family members, friends, providers of health related services, recipient’s physician, and legal guardian, where appropriate, in establishment of the service plan;
- Assisting the participant with identification and selection of approved and enrolled service providers subject to the participant’s choice;
- Assisting the participant with securing necessary physician orders when required for the initiation of any service
- Presenting the ISP (including goals, service providers, frequency, duration of services) to the participant or representative for acceptance;
- Submitting the ISP to MAA for review and approval
- It is the responsibility of the case management service provider to ensure that all other professional disciplines as identified for resolution of identified needs are incorporated into the ISP
- Coordinating all waiver services for the participant so that services provided to participants are delivered in a safe, timely, and cost effective manner; providing supportive counseling to the participant and family as appropriate; and addressing and resolving identified problems;
- Coordinating and monitoring necessary and appropriate services in a timely manner (including twenty-four (24) hour crisis coverage) for the waiver participant as specified in the participant’s ISP;
- Providing information about non-Medicaid programs and services for which the participant might be eligible; referring the participant to the appropriate service as necessary; and providing assistance to the participant in gaining public benefits and linkages to community resources;
- Documenting monthly in-home visits and telephone contacts;
- Reviewing and approving the ISP of the direct care and other service providers in a timely manner, and maintaining copies in the participant’s

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record

- Coordinating multiple services or providers; and providing on-going assessment of the participant’s continued appropriateness for participation in the waiver
- On-going monitoring of the implementation of ISP to ensure quality of care and service provisions
- Ensuring that the participant obtains annual (and as needed) level of care certification, and ensuring that the information is forwarded to MAA prior to the expiration of the current certification period
- Documenting quarterly reviews that provide a synopsis of the participant’s care and outcomes within a defined period
- Maintaining records necessary to provide supportive documentation of all case management service provided

When conducting quarterly reviews, the case manager shall also include the following documentation as part of the complete synopsis of the recipient’s care and outcomes for the defined period

- Utilization of services
- Communication with other providers regarding the participant’s goals and progress;
- Identification and resolution of problems
- Referrals or linkages to community resources

The Case Manager may also use the Medicaid application to assist the participant in acquiring other services through the State and other Federal programs.

- 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 underway to identify, analyze and prioritize risks associated with the EPD Waiver. A Risk Management Plan and a corresponding proposed action (mitigation) plan will be developed and implemented for identified risks. MAA-ODA will spearhead a coordinated approach that will involve each provider agency who will

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This will be summarized and the complete assessment and mitigation plan will be compiled and remain at MAA. A risk assessment database will also be developed for tracking and reporting purposes.

Timeline for Implementation – January 2007

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 participant 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.

Process: Case managers responsible for the participant assessment will identify risks in the

- 18 – 64 years
- 65 – above population

Information obtained from the participant’s health history does assist in the development of the ISP. Information such as:

- Age
- Diagnosis
- Mobility
- Safety/Personal Emergency Response System
- Security
- Meds
- Family/other in-home/support

Characteristics identified are placed in the categories as listed

- Physical and Mental Health Issues
- Home Environment and Activities of Daily Living
- Leisure and Social Activities
- Family and Other support system
- Miscellaneous/Additional Information

Strategies for Risk Assessment: In conjunction with the Quality improvement plan the high risk participants will be targeted. Case managers will conduct the ISP assessment with a frame of reference on identified targeted perceived risks, noting the difficulties participant verbalizes, family/significant other verbalizes, a review of a physician, RN, Rehabilitation specialist or other designee of the physician.

1) Review of Health history with particular emphasis on debilitating diagnosis such as

- Cerebral vascular accidents
- Degenerative arthritis
- Diabetes with amputation
- Delirium
- Visual impairment
- End stage renal disease

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- 2) Decline in ADL's, IADL's
- 3) Medication category such as diuretics, antihypertensive, anti-epileptics, psychoactive, hypnotics, and anti-anxiety
- 4) Infections
- 5) Dehydration
- 6) Behavior symptoms
- 7) Decline in mental status
- 8) Pain

ISPs are reviewed by state Medicaid staff (PHA) and a final analysis of the risk will be addressed with the case manager.

A matrix will guide the case manager in identification of risks.

SAMPLE:

RISK ASSESSMENT TOOL

NAME _____ DATE: _____
 AGENCY _____ CASE MANAGER _____

INSTRUCTIONS: Place a check mark beside any deficits that the participant displays, verbalizes, or has a noted history. Four or more selected characters trigger a risk.

<input type="checkbox"/>	Falls/Bruises
<input type="checkbox"/>	Behavior symptoms
<input type="checkbox"/>	Cognitive Impairment
<input type="checkbox"/>	ADL decline
<input type="checkbox"/>	IADL decline
<input type="checkbox"/>	Vision deficit
<input type="checkbox"/>	Hearing deficit
<input type="checkbox"/>	Dehydration
<input type="checkbox"/>	Pain/discomfort
<input type="checkbox"/>	Rehabilitation
<input type="checkbox"/>	Assistive devices
<input type="checkbox"/>	Dialysis
<input type="checkbox"/>	Medications x 5
<input type="checkbox"/>	Infections
<input type="checkbox"/>	Communication
<input type="checkbox"/>	Aphasia
<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	Immobility
<input type="checkbox"/>	Bedridden
<input type="checkbox"/>	Diagnosis

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PARTICIPANT AT RISK FOR _____

RECOMMENDATIONS FOR MITIGATION _____

Mitigation

The case manager has the responsibility to implement and monitor an action plan to address each high risk participant. Stakeholders in the process are noted as

- Participants
- Home Health agencies
- Case Managers
- State Medicaid

A matrix of the identified characteristics can be reviewed. Case managers should select relevant characteristics and indicate the risk.

Four or more of the characteristics on the matrix can trigger the development of a program to address the risk.

- Policy will be developed to
- Ensure consistent information contained in the plan
- Ensure consistent follow-through of assessed risk
- Identify a consistent tracking mechanism
- Ensure information is recorded in conjunction with a continuous Quality Improvement Plan

Emergency plans (back up plans) are developed by the case manager in conjunction with the participants and/or his family. Plans are consistent with needs:

- Respite care can be arranged with care givers who are in need of substitute supports.
- Primary family members arrange with other family to substitute for PCA
- Primary family members enlist the support of neighbors to assist in the caring of participants.

Emergency plans developed in conjunction with the case manager and family identifies all supports needed for timeframes when agency staff is not available.

Plans include – replacement of support linkages, individual, transportation, modes and other linkages.

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- 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.

Inquiries to the Medicaid Office, to home health care agencies and to community linkages are provided with Medicaid brochures with all agencies providing waiver services. Further, there is a website www.ardcdc.org that also lists information on the EPD waiver services. The signed Waiver Beneficiary Freedom of Choice Form supports participant’s choice.

- 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):

- **Limitations:** This is a choice program and MAA can’t force any waiver service on a participant. That is why participant reviews and agrees to services as indicated in the signed beneficiary freedom of choice form.

Process for making service plan subject to the Approval of the Medicaid Agency:
 The Medicaid agency receives all of the EPD applications, logs them in and reviews all documents. The process is as follows:

- ODA staff logs in application
- Stamps date of receipt on documents
- Assigns applications to Public Health Analyst
- Reviews
 - 30AW Form (Eligibility Determination Form)
 - Medicaid Application
 - Level of Care and submits package of information to Income Maintenance Administration (IMA)
- ODA staff further reviews
 - Individual Service Plan
 - Client Health history
 - Waiver Service Cost Sheet
 - Signed Beneficiary Freedom of Choice
 - Bill of Rights
 - Environmental Assessment
 - Individual Service Plan Agreement

Any documentation not appropriate for Waiver participation is

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- Identified and the provider is called requesting re-do of document or submission
- Information request not provided is returned

Process for making service plan subject to the Approval of the Medicaid Agency:
 The Medicaid agency receives all of the EPD applications, logs them in and reviews all documents. The process is as follows:

- ODA staff logs in application
- Stamps date of receipt on documents
- Assigns applications to Public Health Analyst
- Reviews
 - 30AW Form (Eligibility Determination Form)
 - Medicaid Application
 - Level of Care and submits package of information to Income Maintenance Administration (IMA) for eligibility

ODA staff further reviews:

- Individual Service Plan
- Client Health history
- Waiver Service Cost Sheet
- Signed Beneficiary Freedom of Choice
- Bill of Rights
- Environmental Assessment
- Individual Service Plan Agreement

Any documentation not appropriate for Waiver participation is

- Identified and the provider is called requesting re-do of document or submission
- Information request not provided is returned

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:*

<input type="radio"/>	Every three months or more frequently when necessary
<input type="radio"/>	Every six months or more frequently when necessary
<input checked="" type="radio"/>	Every twelve months or more frequently when necessary
<input type="radio"/>	Other schedule (<i>specify</i>):

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- 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 §74.53. Service plans are maintained by the following (*check each that applies*):

<input checked="" type="checkbox"/>	Medicaid agency
<input checked="" type="checkbox"/>	Operating agency
<input checked="" type="checkbox"/>	Case manager
<input type="checkbox"/>	Other (<i>specify</i>):

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Appendix 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.

- The Home Health agency/service agency (see case management agencies definition) case manager will be responsible for developing and implementing the service plan. The ultimate responsibility for monitoring the plan of care will be conducted by the Case Manager of the agency. However, ODA will review the service plans as they are submitted for admission upon the recertification period.
- Further, quarterly Satisfaction surveys are conducted by the ODA team and at that time ODA staff also ascertain if services requested are the services provided. Plans may also be reviewed during the annual site visits conducted by the team from MAA. ODA staff also conduct random reviews of ISPs and conduct checks upon providers that have exhibited significant changes in service provision. These may include review of ISPs for continuity of care, financial claims details, review of client satisfaction, review of unusual incident logs and telephone interviews and updates with case managers, direct service administrative staff and agency leadership.
- The participant is responsible for selecting the Home Health /service agency they are using and the case managers are sent to the home as referred. If participants are not happy with the Case managers they have received the participant is given the opportunity to select another Case Manager.
- Participants who are referred to the program will usually contact the Office on Disabilities and Aging (ODA) for information on the EPD Waiver process. The ODA staff, in turn send to each requesting participant a copy of the EPD Waiver provider directory, instructions on how to access the Waiver services, the process, and a contact person in ODA with a telephone number.
- ODA will not provide consultation to the participant as to the selection of the Case Manager. However, staff will suggest that participants review the directory and select an agency according to the location nearest their home, in their ward, near the doctors office, or get consultation from a friend/family member to assist in the selection of the provider/Case manager. The DC Aging and Disabilities Resource Center when implemented in 2005 was designed to provide the participants with the needed supports for accessing the Waiver program and other community linkages. This service was interrupted but expected to begin again late in FY 2007. Upon implementation of services, which are expected to be done in house, the linkages for the Elderly and Persons with Physical Disabilities will be restored.
- The plan of care, Individual Service Plan, is the fundamental tool the State will use to ensure the health and welfare of individuals served in this Waiver. Risk assessment will be conducted and outlined as well as mitigation for the risk will be identified beginning in January 2007. Currently a Health History form is completed and identified issues of

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concerned are noted. Issues that present a challenge are addressed by the Case Manager and support as identified are implemented to address the noted deficits. ODA staff that may conduct reviews of the participants documentation also assist in identifying deficits as well as provide suggestion and/or guidance to the Case Managers on the issues. If life threaten situations or any thing poses a threat to health and welfare of the participant the appropriate linkages are made to assess the challenge.

- An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. It will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual’s disability.
- Back-up plans are requested by the Home Health Agencies as a part of the Case Managers assessment; ODA does not request to see the plans, however; the plans must be made available to the Medicaid office upon request. We will however request that all emergency back-up plans be submitted to the State Agency as a component of the ISP.
- Home Care Agencies/ Case Managers/Participants presenting challenges/concerns to the State on or about the participants are entertained: advice is given on supports necessary to address the issue. Home Health/Case managers are requested to submit the information in writing; the state then in turns follows up on the issues with appropriate agencies as identified.
- The minimum schedule under these reviews will occur:
 - 1) updated every 12 months
 - 2) In addition to every 12 months, the plan of care will be reviewed every quarter and/or on an as needed basis whenever a change in the customer’s needs indicate. ISP must be signed by members of the interdisciplinary plans.

CONFLICT OF INTEREST

- The Case management provider may not assign, any immediate family or legal authority representative of a recipient as a case manager
- A case manager may not provide any other Medicaid Waiver services to participants for whom the agency provides case management services
- The Maximum number of Medicaid waiver participants is forty-five [45]
- The Agency must maintain a current participant roster per Case Manager. The information must be available to the Medical Assistance Administration.
- MAA does not encourage the practice of a Case Managers working for more than one agency. In the event a Case Manager works for more than one contracting or employing agency the combined case load must not exceed forty-five (45)
- Failure of an agency to adhere to the policy will result in immediate moratorium until case loads are adjusted to forty-five (45)

METHODS FOR REMEDIATION OF IDENTIFIED PROBLEMS;

- Collect the data, e.g.- physician plan, infrastructure supports, case managers information ,

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- quarterly audits of indicators, etc.
- Conduct an assessment of challenge/concern/participant
 - Review/plan the necessary steps to correct deficits, e.g.- address issue with Quality Improvement Committee
 - Implement the steps identified to address issue i.e. provide advice, support and/or information to address the issue; provide training if necessary and/or suggest community linkages to address the issues
 - Issues address that are high volume, problem prone, high cost, are reported in the quarterly Continuous Quality Improvement. Report.

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

1. A comprehensive assessment and a plan of care will be completed by the case manager for each individual served under the waiver;
2. It is the responsibility of the case manager to submit the completed plan of care and comprehensive assessment forms (along with the signed freedom of choice form) to a representative of the State Agency;
3. Representatives of the State Agency review the comprehensive assessment form and the plan of care;
4. Representatives of the State Agency approve (or disapprove) services and preauthorize approved services; and
5. Representatives of State Agency communicate care plan approval to case manager;
6. Case manager initiates services;

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.
3. A copy of the comprehensive assessment form to be utilized in this waiver is attached to this Appendix (D-2-3).

b. Monitoring Safeguards. Select one:

X	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may not provide</i> other direct waiver services to the participant.
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○	<p>Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> 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. <i>Specify:</i></p> <p>Service plans are monitored by case managers of the agencies and are ultimately reviewed by ODA staff. Guidelines for service plans are outlined in the responsibilities of the standards of the case managers (please see Section B: Standards for Case Management Services). Providers that offer Case Management services as well as Direct Care services.</p> <p>More specifically, the case manager shall document a complete synopsis of the participant’s care and outcomes. The information should include Utilization of services, communication with other providers regarding the participant’s goals and progress, identification and resolution of problems and referrals or linkages to the community resources. Signed Individual Service Plans, Client Health History are sent to the Medical Assistance Administration Office on Disabilities and Aging for review and approval prior to implementation of the services. Home Health care Agencies providing Case Management services may provide other services as listed within the EPD waiver but must be within the scope of the services approved. Conflicts of interest are strongly discouraged, if not prohibited. Home Health care agencies may provide case management, personal care aides, chore aide, homemaker, and Skilled Nursing services as approved by ODA.</p> <p>Prior authorizations for services are provided to each agency prior to implementation and upon recertification of services by ODA.</p> <p>The District utilizes the following monitoring methods and safeguards for enduring that there is no conflict of interest for Case Managers and direct waiver services provided to EPD Waiver participants. First, Case Managers are informed that the Case Manager cannot provide any direct care services of any kind to the participant, Second, ODA staff conducts random telephone satisfaction, surveys of participants on a quarterly basis, and participants are asked about their case managers and also about direct care services, such as who provides the services. Third, EPD Waivers Individual Service plans are developed and monitored by case managers and are also reviewed prior to service implementation by the direct care provider agency, by MAA-ODA staff upon admission to the EPD Waiver, and by ODA staff upon annual recertification. Fourth, each participant, upon admission to the EPD Waiver, is provided information about their rights including the right to choose or select their case manager and direct care service agency. Upon an EPD Waiver inquiry of services and upon admission, each participant is mailed an EPD Waiver brochure which outlines all services. This information also can be found on the www.adrcdc.org website. The participant is required to sign a beneficiary freedom of choice form that indicates that the participants is aware of and has made a free and willing choice of direct care provider and case manager. Fifth, and finally, MAA-ODA staff will conduct random home visits to speak directly with participants and then also follow-up with Case managers. This information is collected by MAA-ODA staff and compiled on a quarterly basis and reviewed for emerging trends.</p>
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**DISTRICT OF COLUMBIA GOVERNMENT
 DEPARTMENT OF HEALTH
 MEDICAL ASSISTANCE ADMINISTRATION**

**HOME AND COMMUNITY-BASED WAIVER FOR THE ELDERLY AND INDIVIDUALS WITH
 PHYSICAL DISABILITIES**

**CASE MANAGEMENT
Individual Service Plan**

Date: _____

Part I Identification Data

Customer: _____

Medicaid No. _____

Address: _____

DOB: _____

Case Management Provider: _____

Telephone Number: _____

Address: _____

Level of Care Date: _____

Case Manager: _____

Provider Number: _____

Telephone Number: _____

Fax Number: _____

Service Start Date: _____ Service End Date: _____ Plan of Care Date: _____

Quarterly Review Dates: _____



A. PHYSICAL AND MENTAL HEALTH ISSUES

CURRENT STATUS	REQUESTED SUPPORT SERVICES

ISP - Case Manager 03/31/06

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Customer: _____

Medicaid No. _____

- B. HOME ENVIRONMENT AND ACTIVITIES OF DAILY LIVING**
- C. LEISURE AND SOCIAL ACTIVITIES**
- D. FAMILY AND OTHER SUPPORT SYSTEMS**
- E. MISCELLANEOUS/ADDITIONAL INFORMATION**

CURRENT STATUS	REQUESTED SUPPORT SERVICES

Customer: _____

Medicaid No. _____

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GOALS/DESIRED OUTCOMES:

OBJECTIVES	TARGET DATE	ACTIVITIES/STRATEGIES (Frequency, if applicable)

INDIVIDUAL SERVICE PLAN

DOCUMENTATION OF AGREEMENT

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Customer: _____
CM Provider: _____
Case Manager: _____

Medicaid Number: _____
Provider Number: _____
Telephone Number: _____



We, the undersigned, have participated in the review of this Individual Service Plan and agree that the services recommended and responsibilities designated will be implemented. In addition, the customer and/or his/her designee have been informed of all available WAIVER providers and the customer and/or his/her designee had the option of choosing from among those providers which can appropriately meet his/her needs.

SIGNATURE	TITLE	DATE



Quarterly Review/Update of ISP:

_____	_____	_____
Signature	Title	Date
_____	_____	_____
Signature	Title	Date
_____	_____	_____
Signature	Title	Date
_____	_____	_____
Signature	Title	Date

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Customer: _____

Medicaid No. _____

ELDERLY AND PHYSICAL DISABILITIES WAIVER COSTS

SERVICE	COST	UNITS/FRE- QUENCY PER/WEEK	TOTAL UNITS P/YEAR	TOTAL COST
CASE MANAGEMENT	\$500.00 (Comp. Asses)			
CASE MANAGEMENT	\$225.00 (Ann/Re-Asses)			
CASE MANAGEMENT	\$125.00 (Per Month)			
CHORE AIDE	\$15.00 (Per Hour)			
HOMEMAKER	\$10.50 (Per Hour)			
PERSONAL CARE (subtract the cost of 1040 hours of State Plan services)	\$16.30 (Per Hour)			
RESPIRE (Hourly)	\$16.30 (Per Hour) for 1 to 17 hours/day			
RESPIRE (Per Day)	\$300.00 (Per day) for 18 -24 hours/day			
ASSISTED LIVING	\$60/ DAY			
ENVIRONMENTAL ADAPTATION	\$10,000.00 (p/customer)			
PERSONAL EMERGENCY RESPONSE SERVICES (PERS) (Install)	\$40.00 (Installation)			
PERSONAL EMERGENCY RESPONSE SERVICES (PERS) (Monthly Fee)	\$28.50 (Per Month)			

TOTAL WAIVER COST: _____

Case Manager's Signature Title _____

Date _____

() Approved _____ () Disapproved _____
 MAA Staff Date

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Appendix E: Participant Direction of Services

[NOTE: Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.]

Applicability (select one):

	Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
X	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):

<input type="radio"/>	Yes. The State requests that this waiver be considered for Independence Plus designation.
<input type="radio"/>	No. Independence Plus designation is not requested.

Appendix E-1: Overview

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.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

<input type="radio"/>	Participant – Employer Authority. As specified in <i>Appendix E-2, Item a</i> , 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.
<input type="radio"/>	Participant – Budget Authority. As specified in <i>Appendix E-2, Item b</i> , 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.
<input checked="" type="radio"/>	Both Authorities. The waiver provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . 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:*

<input type="radio"/>	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
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<input type="checkbox"/>	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.
<input type="checkbox"/>	The participant direction opportunities are available to persons in the following other living arrangements (<i>specify</i>):

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

<input type="radio"/>	Waiver is designed to support only individuals who want to direct their services.
<input type="radio"/>	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.
<input type="radio"/>	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. <i>Specify the criteria:</i>

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.

f. Participant Direction by a Representative. Specify the State’s policy concerning the direction of waiver services by a representative (*select one*):

<input type="radio"/>	The State does not provide for the direction of waiver services by a representative.
<input type="radio"/>	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: (<i>check each that applies</i>):
<input type="checkbox"/>	Waiver services may be directed by a legal representative of the participant.
<input type="checkbox"/>	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:

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-3. (*Check the opportunity or opportunities available for each service*):

Participant-Directed Waiver Service	Employer Authority	Budget Authority

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	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

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. <i>(Complete item E-1-i). Specify whether governmental and/or private entities furnish these services. Check each that applies:</i>
	<input type="checkbox"/>	Governmental entities
	<input type="checkbox"/>	Private entities
<input type="checkbox"/>		No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

<input type="checkbox"/>		FMS are covered as the waiver service entitled As specified in Appendix C-3.
<input type="checkbox"/>		FMS are provided as an administrative activity. <i>Provide the following information:</i>
	i.	Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:
	ii.	Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:
	iii.	Scope of FMS. Specify the scope of the supports that FMS entities provide <i>(check each that applies):</i>
		<i>Supports furnished when the participant is the employer of direct support workers:</i>
		<input type="checkbox"/> Assist participant in verifying support worker citizenship status
		<input type="checkbox"/> Collect and process timesheets of support workers
		<input type="checkbox"/> Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
		<input type="checkbox"/> Other <i>(specify):</i>
		<i>Supports furnished when the participant exercises budget authority:</i>
		<input type="checkbox"/> Maintain a separate account for each participant's participant-directed budget
		<input type="checkbox"/> Track and report participant funds, disbursements and the balance-of participant funds
		<input type="checkbox"/> Process and pay invoices for goods and services approved in the service plan
		<input type="checkbox"/> Provide participant with periodic reports of expenditures and the status of the participant-directed budget

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<input type="checkbox"/>		Other services and supports (<i>specify</i>):	
		<i>Additional functions/activities:</i>	
		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	
	<input type="checkbox"/>	Other (<i>specify</i>):	
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.	

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*):

<input type="checkbox"/>		Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:</i>	
<input type="checkbox"/>		Waiver Service Coverage. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled:	
<input type="checkbox"/>		Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. <i>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:</i>	

k. Independent Advocacy (*select one*).

<input type="checkbox"/>		Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i>	

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No. Arrangements have not been made for independent advocacy.

i. 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:

--

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.

--

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		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

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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. *Check all that apply:*

	Reallocate funds among services included in the budget
	Determine the amount paid for services within the State’s established limits
	Substitute service providers
	Schedule the provision of services
<input type="checkbox"/>	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
	Identify service providers and refer for provider enrollment
<input type="checkbox"/>	Authorize payment for waiver goods and services
	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other (<i>specify</i>):

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.

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.

iv. Participant Exercise of Budget Flexibility. *Select one:*

<input type="radio"/>	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:
	Modifications to the participant-directed budget must be preceded by a change in the service plan.

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- 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:

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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.

Any individual seeking Medicaid services are offered opportunities to request a fair hearing. In addition, each participant is informed of their right to choose the provider of their choice for service. Should they be denied service or admittance to the EPD Waiver the participant has the right to request a fair hearing.

Official introduction to the Waiver resources are provided by the MAA Office on Disabilities and Aging that also include information on the right to a fair hearing, and information on how to request a fair hearing. For example persons interested in the EPD Waiver receive an EPD Waiver brochure, EPD provider directory and instructions on how to access the EPD Waiver Program. Also shared is information on the fair hearing process such as if denied service or there is a dispute that is not reconciled through dialogue with the Medicaid provider or with Medicaid Office. In accordance with the District municipal regulations the DOH-Office on Administrative Hearings ultimately grants individuals and/ or providers the opportunity to receive a fair hearing based on a request. Each participant is given the opportunity to request a fair hearing in writing and is given information on location to send fair hearing request. The following **instances are described when notices must be made to an individual of a denial of service:** HCBS and institutional services are choice services selected by the participant. The District maintains no responsibility for the participant's choice; as clarified in the Beneficiary Freedom of Choice form signed by each potential service recipient. When a participant is informed of his ineligibility for Medicaid and thus the HCBS (EPD) Waiver the Income Maintenance Administration sends a denial letter to the participant and the Case Manager usually calls and discusses the reasons for the denial with the potential service recipient. If the participant is denied a Level of Care by the Quality Improvement Organization Delmarva, a denial letter which includes the information on how to access the fair hearing process is sent to the participant.

- **When a participant is discharged or terminated for service he must be given 30 days written notice by the agency. The case manager is also responsible for assisting the participant in pursuing any necessary action, if necessary.**
- **A participant is informed that services will continue during the period while the participant's appeal is under consideration.** If the participant is not eligible for Medicaid no services will have started. If the participant is not eligible based on the level of care then services have not started and the appeal process may be initiated by the participant. If participant's services have been terminated and/or suspended the agency should continue services until some arrangements can be made for continuation of services. Notification will be made to the individual by the agency.

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- All notices of fair hearings and requests are maintained in the District’s Office of Fair Hearings and the Office of the Attorney General for the Medical Assistance Administration (Medicaid).
See Attached – Appellants’ Bill of Rights and Request for a Hearing Case form.

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Attachment to F-1

**Office of Administrative Hearings
825 North Capitol Street
Washington, DC 20002
Telephone Number 202-724-5431
Facsimile Number 202-724-4129**

APPELLANT'S BILL OF RIGHTS

Pursuant to D.C. Code 1-1509 you are hereby given notice of the following matters relating to the hearing which you have requested:

You have the right to be represented by an authorized representative, such as legal counsel, relative, friend, other spokesman, or you may represent yourself.

You have the right to bring witnesses to the hearing and to present your case without interference. You may try to disprove any evidence presented by the Agency, and you may question all witnesses.

If you or your witness does not speak English, is deaf, or because of a hearing impediment cannot understand or communicate the spoken English language, you or your witness may request an interpreter

The hearing will be conducted by a hearing examiner in accordance with the provisions of D.C. Code Section 1-1509.

The hearing will be similar to a court proceeding, but not as formal. The purpose of the hearing is to obtain facts about your case that will allow the hearing examiner to make a proper determination. The hearing examiner will rule on all matters at the hearing.

A witness must testify under oath or affirmation to tell the truth. You may request the appearance of agency witnesses. While the hearing officer does not have authority to compel agency witnesses to appear, the Office of Fair Hearings will refer your request for witnesses to the agency head for compliance.

You should be prepared to present evidence to support any fact you state or any position you take at the hearing. You must be prepared to testify and present evidence that will support your position, such as the notices, letters, or records you have about the agency action you are appealing.

At the hearing, you should be prepared to present evidence to support any fact or position you state.

The following kinds of evidence are admissible:

- (1) **Knowledge of the Agency**: The agency may take "official notice" of conclusions developed as a result of its intensive experience in its specialized field of activity. You will be informed at the hearing if the agency took "official notice" of any fact and will be given the

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opportunity to contest any facts so noticed.

- (2) Testimony of Witnesses: This includes your own testimony.
- (3) Writings: This includes all notices, records, letters, maps, or other written information you have about the hearing issue.
- (4) Experiments, demonstrations and similar means used to prove a fact.

You may object to the admissibility of evidence generally on one of the following grounds in accordance with D.C. Code 1-1509 (b).

- (1) Irrelevant: The evidence has no tendency to prove or disprove any issue involved in the proceeding.
- (2) Immaterial: The evidence is offered to prove a proposition which is not a matter in issue.
- (3) Unduly repetitious: The evidence is merely repetitive of what has already been offered and admitted only.

Hearsay evidence is not automatically excluded. Objection to hearsay evidence generally related to the weight to be given to the evidence. In reaching a decision, the hearing examiner will only consider evidence which has been admitted only.

Inform the hearing examiner if at any time during the hearing you decide that you want representation by an attorney. The hearing examiner, in his or her discretion, may grant a recess to allow you to secure an attorney.

A record will be made of the entire proceeding. This will be done by use of a court reporter or tape recording.

The agency may be represented by an attorney at the hearing only if you are represented by an attorney. Parties are not ordinarily represented by an attorney in these hearings. If you desire legal representation, you may wish to contact one of the organizations listed on your hearing notice.

The hearing examiner is an employee with the agency and does not have authority to make a final, independent determination.

The hearing examiner will serve upon the parties a proposed order, including findings of fact and conclusions of law. That order will tell you how to file written exceptions to the proposed order; when oral argument may be made to the director; and who will render the final order.

After the hearing, there will be no continuance or reopening of the hearing to offer additional evidence unless you can show that the additional evidence was not known to you at the time of the hearing or that reasonable diligence would not have discovered the evidence prior to the hearing.

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You may appeal the final order to the D.C. Court of Appeals if it is adverse to you. You must file a petition for such judicial review within 90 days following the date the final decision is served upon you.

The record of the hearing will be used by the Court of Appeals in considering any appeal of the agency's decision. The record will include all testimony, rulings on objections, evidence and exhibits presented during the hearing, and will be reviewed by the court to determine if the agency's order should be upheld.

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**DISTRICT OF COLUMBIA
Office of Administrative Hearings
441 4th Street, NW, Suite 540-South
Washington, DC 20001**

REQUEST FOR A HEARING IN A PUBLIC BENEFITS CASE

Section 1 I am a(n): **APPLICANT** for benefits **RECIPIENT** of benefits

I am requesting a hearing because I disagree with the action(s) regarding the following program(s):

- Food Stamps (FS) Medicaid DC (MA)
 Interim Disability Assistance (IDA) General Assistance for Children (GAC)
 Energy Assistance (EA) (DPW/Office of Energy) Program on Work, Employment & Responsibility (POWER)
 Rehabilitation Services (RSA) Emergency Shelter (SHELTER)
 Temporary Assistance for Needy Families (TANF) Child Care
 Other (please specify)

Section 2 Reason(s) For Disagreeing with Agency's action: (additional space on back if needed) _____

Section 3 What do you want the judge to do? (additional space on back if needed) _____

Section 4 **DOLLAR AMOUNT** of any benefits or assistance that you are seeking (please check one): maximum benefit for my household size, or \$ _____ per month in benefits **OR** The overpayment amount I believe I should not have to pay (\$ _____)

Section 5 Do you require special services of any kind to help you participate in the hearing? (Language translation, sign language interpreter, etc.) Yes No If Yes, what service is required?

Section 6 – Contact Information

Name of Applicant/Recipient (please print): _____ **Date:** _____

Address: _____ **Case** _____

City, State, Zip: _____ **Case Worker:** _____

Telephone No.: _____ **Center:** _____

Signature: _____ **Telephone No.:** _____

Number of People in Household: _____ **Supervisor:** _____

Attorney/Representative (if any): _____ **Center Manager:** _____

Name: Print name: _____ **Person preparing request (if other than applicant):** _____

Signature: _____ **Address:** _____

City, State, Zip: _____ **Office/Center (if DHS):** _____

Telephone No.: _____ **Telephone No.:** _____

COMPLETE AND SUBMIT A CERTIFICATE OF SERVICE ON THE BACK OF THIS FORM CERTIFYING THAT YOU HAVE SERVED AGENCY REPRESENTATIVES WITH THIS HEARING REQUEST. THE SUBMISSION OF A FALSE STATEMENT ON THIS FORM OR THE CERTIFICATE OF SERVICE IS A CRIME PUNISHABLE UNDER D.C. OFFICIAL CODE § 22-2405.

Form OAH-431, Rev. 05-04

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Add Additional Documentation as Needed or Use Writing Space Below

CERTIFICATE OF SERVICE

I certify that a copy of this document was served by: First-Class Mail Hand Delivery Fax

to the APPLICANT/RECIPIENT on the reverse (if prepared by someone other than the applicant/recipient), on the General Counsel, **and** on any program checked below (you must check each program checked on the reverse).

Signature: _____

Date: _____

For the General Counsel's Office:

John Dodge, Esq.
Office of the General Counsel
N.E. – 10th Floor
64 New York Avenue, NE 6th Floor
Washington, DC 20002
FAX: (202) 279-6158

For Rehabilitation Services:

John Tolbert
Department of Human Services
810 First Street,
Rehabilitation Services Administration (RSA)
Washington, D.C. 20002
FAX: (202) 543 - 5653

For FS, IDA, MA, GAC, TANF, POWER:

Ellen Wells
Department of Human Services
Prevention of Income Maintenance

Administration (IMA)
645 H Street, NE, Suite 5000
Washington, DC 20002
FAX: (202) 724-2041

For Emergency Shelter:

Cornell Chappelle
The Community Partnership for the
Homelessness
801 Pennsylvania Avenue, SE Suite 360
Washington, DC 20003
FAX: (202) 543-5653

For Energy Assistance:

Richard Kirby
D.C. Energy Office
2000 14th Street, NW, 300 East
Washington, DC 20009
FAX: (202) 673-6725

For Child Care:

Barbara Kamara
Executive Director
Office of Early Childhood Development
717 15th Street NW
Washington, DC 20005

For DC Medicaid

Thomas Collier
Department of Health
Medical Assistance Administration
825 North Capitol Street
Washington, DC 20002

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ORGANIZATIONS THAT MIGHT BE ABLE TO HELP YOU WITH YOUR APPEAL

There are several organizations in the District of Columbia that might be able to represent you in connection with your appeal. These organizations are not connected with the Department of Human Services in any way. They are independent and have different conditions under which legal assistance can be provided. If you would like to see if one of these groups can represent you, you should contact them immediately. Always call the organization first, to see if they can help you.

Neighborhood Legal Services Program

Offices

NLS - Main Office
701 4th St., N.W.
Washington, D.C. 20001
Phone No. (202) 682-2700

NLS - Office
1213 Good Hope Road, S.E.
Washington, D.C. 20020
Phone No. (202) 678-2000

Other Legal Services

Legal The Legal Aid Society
666 11th St., NW
Washington, D.C. 20001
Phone No. (202)682-2700

The Catholic University of America
Columbia School of Law
Columbia Community Legal Services
3602 John McCormack Road, N.E.
Washington, D.C. 20064
Phone No. (202)319-6788
Fax No. (202)319-6780

University Legal Services
300 I Street, N.E. Suite 202
Washington, D.C 20002
Phone No. (202)547-4747

Civil Practice Clinic
American University
4801 Massachusetts Avenue, Suite 417
Washington, D.C. 20016-8184
Phone No. (202)274-4140
Fax No. (202)274-0659

Women and the Law Clinic
The American University College
College of Law
4801 Massachusetts Ave. N.W.
Washington, D.C. 20016
Phone No. (202)274-4140

Community Legal Clinic
George Washington University
Suite SL - 101
2000 G Street, N.W.
Washington, D.C. 20052
Phone No. (202)994-7463

Legal Counsel for the Elderly
601 E St., N.W. Bldg. A - 4th Floor
Washington, D.C. 20049
Phone No. (202)662-4933

Ayuda Para El Consumidor
1736 Columbia Road, N.W.
Washington, D.C. 20009
Phone No. (202) 387-4848

The Legal Aid Society
Family/Landlord and Tenant
515 5th St. N.W.
Washington, D.C. 20001
Landlord & Tenant (202)727-1785

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Legal Aid Society Family Svcs.(202)727-2147

Anny Blaine Harrison Institute
 For Public Law
 605 G Street, N.W. Room 401
 Washington, D.C. 20001
 Phone No. (202)624-8235

Washington Legal Clinic for the Homeless
 1800 Massachusetts Ave., N.W.
 6th Floor
 Washington, D.C. 20036
 Phone No. (202)872-1494

Bread for the City
 1525 7th Street, N.W.
 Washington, D.C. 20001
 Phone No. (202)332-0440

The Mental Health Law Project
 1101 15th Street, N.W.
 Suite 1212
 Washington, D.C. 20005
 Phone No. (202)467-5730
 Fax No. (202)223-0409
 (Cases involving PASARR requirements)

University of the District of Columbia
 School of Law
 4250 Connecticut Avenue, N.W.
 Washington, D.C. 20008
 Phone No. (202)274-7313

Marshall Heights Community
 Development Organization
 3917 Minnesota Avenue, N.E.
 Second Floor
 Washington, D.C. 20019
 Phone No. (202) 396-1200

Zacchaeus Legal Clinic
 1525 7th Street, N.W.
 Washington, D.C. 20001
 Phone No. (202)265-2400

George Washington University
 Suite SL-101
 720 20th Street, N.W.
 Washington, D.C. 20052
 Phone No. (202)994-7463

Georgetown University Law Center
 Family Poverty Clinic
 600 New Jersey Avenue, N.W.
 Washington, D.C. 20001
 Phone No. (202)662-9543
 And (202)662-9074

D.C. Law Students in Court Program
 702 H Street, N.W.
 Suite 400
 Washington, D.C. 20001
 Phone No. (202)638-4798

D.C. Long Term Care
 Ombudsman Program
 Legal Counsel for the Elderly
 1133 20th Street, N.W. 6th Floor
 Washington, D.C. 20037
 Phone No. (202)872-1494

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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:*

<input type="radio"/>	Yes. The State operates an additional dispute resolution process (<i>complete Item b</i>) N/A
<input checked="" type="radio"/>	No. This Appendix does not apply (<i>do not complete Item b</i>)

- 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.

N/A

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Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

<input checked="" type="checkbox"/>	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 (<i>complete the remaining items</i>).
<input type="checkbox"/>	No. This Appendix does not apply (<i>do not complete the remaining items</i>).

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Department of Health Medical Assistance Administration maintains a process for addressing all EPD Waiver related complaints. The participant is informed that filing a grievance or complaint is not a prerequisite or substitute for a fair hearing. The participant has the right to utilize the complaints process by writing a letter to the MAA Director, requesting a Fair Hearing or taking additional action through litigation. The participant is not bound by the MAA complaint process from taking legal action at any time. The MAA complaint process includes the District of Columbia the Office on Administrative Hearings which is responsible for the fair hearing process for resolving formal grievances and complaints. A complainant need not go through the grievance process prior to requesting a fair hearing.

The grievance process is handled on two levels, verbal and in writing. Complaints, both verbal and in writing, are received by MAA-ODA staff and by the MAA Senior Deputy Director’s Office. Each complaint or grievance receives personal attention, as warranted. The DOH Health Regulation Administration receive copies of all provider related complaints from MAA-ODA and take action, as needed.

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).

Provider agencies must be committed to providing the best possible working relations for clients/families/representatives. Part of this commitment is to encourage an open and frank atmosphere in which any problem, complaint, suggestion, grievance, or question can be addressed quickly and accurately by management. Case managers are also asked to review with participants that they will not be penalized or suffer any reprisal as a result of filing a grievance. Clients shall not be penalized or suffer any reprisals as a result of filing a grievance procedure. This statement is indicated on the participants Bill of Rights and Responsibilities. Complaints may be verbal or written. Complaints may come directly from clients/representatives, providers, concerned citizens, and/or public agencies. All complaints will be logged, investigated, and resolved in a timely manner.

a) The grievance process is handled on two levels, verbal and in writing. Complaints, both verbal and in writing, are received by MAA-ODA staff and by the MAA Senior Deputy Director’s Office. Each complaint or grievance receives personal attention, as warranted.

b) The following complaints/grievance process is used:
 Procedures:

1. The following information is collected at the time a complaint is received:
 - Complainant information (name, address, telephone number, etc.)

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- Individuals involved and affected, witness, and accusers
- Allegation categories (abuse, neglect, lack of or inconsistency in the provision of services, failure to provide appropriate care or medical intervention, etc)
- Narrative/specifics of allegation/incident
- If the complainant believes that this is an isolated event or a systematic problem and why and how the complainant believes the incident occurred
- Date and time of allegation
- Date/time/frequency of incidence occurrence
- Location of the incident
- Courses of action initiated
- Complainants expectation/desire for resolution, if any

c) MAA reviews collected data, investigates allegations, if provider related complaints MAA requests written account from provider within fourteen calendar days of notice. Information included in the account should be the occurrence, participants involved, any witnesses, physical injuries, as indicated, hospital injuries, as indicated, challenges identified and resolution of identified challenges. Provider must also identify deficiencies and corrective action plan. Participants are contacted to indicate what the corrective action plans are and their right to Fair Hearing, if wanted. The following District laws govern these policies and procedures: D.C. Municipal Regulation (DCMR) Incidents and Complaints Chapter 42, Title 29; and Home Care Agencies Complaint Process, Chapter 39, Title 22.

On admission to the EPD Waiver program the MAA-Office on Disabilities on Aging Bill of Rights and Responsibilities Form (Revised) is signed by customer and reflects language that clearly states that the customer shall not be penalized or suffer any reprisals as a result of filing a grievance. The Revised Bill of Rights Form appears below:

**DEPARTMENT OF HEALTH
 MEDICAL ASSISTANCE ADMINISTRATION
 OFFICE ON DISABILITIES AND AGING**

BILL OF RIGHTS & RESPONSIBILITIES

RIGHTS

As a home and community-based services customer, you have the right to be informed of your rights and responsibilities before the initiation of home and community-based services. If a customer has been deemed incompetent to make health care decisions, the customer's family and/or representative may exercise the right to make informed decisions for the customer.

The participant is informed that filing a grievance or complaint is not a prerequisite or substitute for a fair hearing.

As a home and community-based services customer, you have the right to:

1. Be informed in advance about the proposed services and be provided a response to questions in understandable terms.
2. Receive services appropriate to your needs, and expect the provider to render safe, professional services at the level of intensity needed without unlawful restriction by reason of age, sex, religion, race, color, creed, national origin, place of residence, sexual orientation, or disability.
3. Receive in writing and orally in advance of care, the services offered, coverage of the services by the payment source, a statement of charges and items not covered by the payment source, and any changes in charges or items and services within 15 days after the provider is aware of a change.
4. Obtain a reasonable response to request for services within the capacity of the provider to respond.
5. Have knowledge of available choices of providers, to participate in your care planning from admission to

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- discharge, and to be informed in a reasonable time of anticipated discharge and/or transfer of services.
6. Receive services from staff that are qualified through education and/or experience to render the services to which they are assigned.
 7. Know who is responsible for and who is providing care, and to receive information concerning your continuing health needs and choices for meeting those needs, and to be involved in discharge planning, if appropriate.
 8. Receive reasonable continuity of care.
 9. Refuse treatment to the extent provided by law, and to be informed of the medical consequences of that refusal.
 10. Receive confidential treatment of your clinical records in accordance with legal requirements, and to be responsible for prior authorizing any release of information contained therein.
 11. Treated with consideration, respect, and dignity, including the provision of privacy during the provision of services.
 12. Inspect or receive, for a reasonable fee, a copy of your clinical records; to have information in your clinical record corrected (as appropriate); and to transfer information to any third party, unless against medical advice.
 13. Receive available information about community resources that are best suited to your care needs
 14. Present grievances and/or recommend changes in your services without fear of discrimination, reprisal, restraint, interference, or coercion.
 15. The customer shall not be penalized or suffer any reprisals as a result of filing a grievance.

RESPONSIBILITIES

Each customer who is receiving home and community-based services has the responsibility to:

1. Provide a complete and accurate health history and any changes in condition, insurance, address, phone number, and other pertinent information.
2. Indicate level of understanding of the plan of care and other expectations in the provision of services
3. Comply with the prescribed plan of care
4. Treat the providers of services with dignity, courtesy, and respect
5. Notify the provider if unavailable for scheduled visits

 Signature of Customer/Representative

 Signature/Title of Provider

 Date

The Complaint Form will be completed and complaints will be registered on the Complaint Log.

1. All complaints will be logged, triaged, prioritized, investigated, and resolved in a timely manner. The complaint must be investigated within ten (10) days of its receipt. Referrals may be made to protection and advocacy agencies, as needed.

These provider staff must be available to assist clients/representatives in resolving disagreements and problems.

A visit must be made to the client's home and/or the provider agency if the nature of the complaint mitigates the need for an on-site visit to the client's home and/or the provider.

2. A client/representative will be allowed the opportunity to discuss the issue with the

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employee/provider agency. The agency will consult with anyone necessary in order to reach a correct, impartial, and equitable determination. The supervisor will give the client/respective an answer as quickly as possible, but within five (5) working days.

3. If the client/representative is not satisfied with the immediate supervisor's response, or if he/she fails to receive an answer within the specified time period, the client/representative can request a meeting with the Chief, Office on Disabilities and Aging.
4. If the problem concerns the immediate supervisor and the client/representative is uncomfortable with discussing the issue with the immediate supervisor, he/she should go directly to the Chief, Office on Disabilities and Aging or their designee. The Chief, Office on Disabilities and Aging will consult with anyone necessary in order to reach a fair decision and should have an answer for the client/representative within five (5) working days.
5. If the client/representative is dissatisfied with the Chief's response, he/she may request that the Senior Deputy Director respond to his/her concerns. The Senior Deputy Director will consult with anyone necessary in order to gain pertinent information and will review the facts.
6. The Senior Deputy Director will contact the client/representative as soon as possible, but within (5) working days, and inform him/her of the date and time to meet with the Senior Deputy Director to review the problem.
7. Once the client/representative has presented his/her concerns (verbally or in writing), the Senior Deputy Director will make sure every effort to make a decision and respond in writing to the client/representative within (5) working days after the meeting.
8. The decision made by the Senior Deputy Director will serve as the final determination concerning the client/representative's problem.
9. If the client/representative still remains dissatisfied with the decision made by the Senior Deputy Director, he/she may resort to other legal means of recourse and Fair hearing laws which he/she chooses. The client/representative may also file a complaint with the Medical Assistance Administration by calling or writing to the following:

Attention: Chief, Office on Disabilities and Aging
 Medical Assistance Administration
 825 North Capitol Street, NE, Suite 5135
 Washington, DC 20002
 Phone: (202) 442-9076
 Fax: (202) 442-4790

Clients' files with the Medical Assistance Administration will be logged, investigated, and resolved as soon as possible following steps #1 through #4 as delineated above. If the clients dissatisfied with the decision, a request for a Fair Hearing may be pursued.

The client/representative may contact the District of Columbia's Administrative Hearing Officer by writing or calling the following:

Attention: Chief, Office of Administrative Hearings
 441 4th Street, NW, Suite 540
 Washington, DC 20001
 Phone: (202) 727-8280
 Fax: (202) 442-4789

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or

Attention: Chief, Office of Administrative Hearings
Office of Administrative Hearings
825 North Capitol Street, NE, Suite 4150
Washington, DC 20002
Phone: (202) 442-9094
Fax: (202) 442-4789

The client/representative may contact the District of Columbia's Home Health Hotline by writing or calling the following:

Health Regulation Administration, Health Facility Division
Licensing and Regulation Administration
825 North Capitol Street, NE – 2nd Floor
Washington, DC 20002
Phone: (202) 442-5833

10. The complainant and the provider who were investigated must be provided with a written summary report of the findings of the investigation to allow for an opportunity for further discussions. The report serves as a record of the investigation.
11. MAA will perform follow-up monitoring of all complaints made against providers to determine if patterns of behavior exist or if the complaint is an isolated event.
12. If multiple complaints are levied regarding the same provider agency, or there is evidence of past noncompliance, MAA will cite this information in the provider's Statement of Deficiencies under the appropriate tag(s).
13. MAA may also elect to refer the complaint to other agencies (such as the Office of Program Integrity, Adult Protective Services, health Regulations Administration, Office of Investigation and Compliance, or the Office of the Inspector General) for further investigation and/or resolution based on the nature of the complaint.
14. Sanctions such as civil monetary penalties or termination of the provider agreement may be imposed against the provider.

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Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. **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 types of reviews that require immediate reporting consistent with District and/or Medicaid law and regulation include:

- alleged abandonment- Adult Protective Services
- abuse and/ or neglect – Adult Protective Services
- Fraud, - Office of Program Integrity, Office of Program Operations, Office of Inspector General
- Poor quality of care , Health Regulation Administration

Critical incidents are generated by the agency/person that has first hand knowledge and responsibility for the incident/complaint. The monitoring agency MAA requires that a provider submit a narrative that gives information on the incident.

According to the DCMR 4235.1 Incidents and Complaint

- Each provider of waiver services shall document, report, investigate, and resolve all incidents and complaints. Each provider of waiver services shall forward a copy of each unusual incident report or complaint to the MAA and shall maintain a copy of all incidents and complaints on file for a period of not less than six (6) years. We also request that the information include a corrective action plan.

Critical events or incidents reported as unusual are reviewed and follow-up action as appropriate is provided by the Medical Assistance Administration Office on Disabilities and Aging. ODA prioritizes investigations based on the nature of the incident. In case of alleged abandonment, abuse and or neglect or other unusual incident typically when someone is injured and/ or death occurs, the reporting period is immediate up to 24 hours for written reports which are faxed to the MAA-ODA Office. Once reports are received, in instances such as these, provider agencies are contacted by ODA within 48 hours or immediately if there is potential harm to recipient that has not been resolved. ODA seeks upon report notice to obtain more information, conduct investigative review to ensure the health, well being and safety of Medicaid participant. MAA-ODA refers all cases involving providers and abuse to the appropriate offices. These include follow-up review which is conducted by the Medicaid Office of Program Integrity, the DOH Health Regulation Administration, and/or the DC Office of the Inspector General, as appropriate. In cases of adult abuse or neglect, there is no formal period for timely reporting although the expectation is that the ODA will act immediately. There are no identified timelines for reporting incidents of abuse, neglect, abandonment, (treated as neglect) or fraud. The response as notified is immediate to 48 hours. Cases of abuse or neglect reported to Adult Protective Services typically require investigation. Cases referred to Adult Protective Services that are investigated result in both APS and the Metropolitan Police Department visiting the home as required by District law. Each investigation, once complete, typically are identified as founded, unfounded or unsubstantiated. The requirements for reporting by the Metropolitan Police Department are slightly different and

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reporting adult abuse and neglect is not mandatory. Within the Police Department these cases most often are treated as assault cases. Potential fraud cases are checked against the MMIS and are referred to the MAA Office of Program Integrity which houses the Medicaid Surveillance, Utilization and Review and the Investigations and Compliance Units. Inquiries that lead to investigations can be immediate to within thirty days depending on perceived threat to health and welfare of Medicaid participant. ODA requests that all providers adhere to the 24 hour written notification period to be able to act quickly in following up with participant and the need to involve other agencies, as appropriate. If the incidents are not reported in a timely manner ODA will not know of the abuse. Therefore, we request immediate up to 24 hour reporting, but ODA prioritizes investigations based on the nature of the incident.

- b. 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: Each interested person is given information concerning the EPD Waiver and the protections and safeguards that are afforded them. This information is shared with each person by ODA when sending out the information. Each participant is also offered information described in detail on the adrcdc.org website. In addition, each case manager is required to explain each of the services and the way in which the program is operated. At the conclusion of this training each participant or their designee is required to sign a beneficiary freedom of choice form. This form indicates that the services and training information have been offered and the participant's signature acknowledges that the information has been explained to them and that they give permission to begin the Waiver program

Once a participant is enrolled in the Waiver families and participants are invited and specific training topics are offered during Quarterly Provider Forums and issues concerning abuse, neglect, and exploitation are discussed, as warranted. Specific information concerning abuse and neglect cases are shared with the District Adult Protective Services and or the Medicaid Fraud Control Unit, as requested. MAA refers all cases of suspected neglect, abuse and/or exploitation to the District (State Agency) Adult Protective Services. Typically one specialized forum on Abuse and Neglect is hosted annually by MAA for providers with speakers from the Medicaid Fraud Control Unit.

- c. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receive 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.

The Office on Disabilities and Aging maintains a data base of all Medicaid EPD Waiver participant. The MAA –ODA also shares information as warranted with the Office of Program Integrity. ODA also receives information on critical events or incidents and share reports with Adult Protective Services, Office of the Inspector General- Medicaid Fraud Control Unit, as warranted. MAA-ODA can disseminate the required information to all appropriate entities necessary to ensure access to the recipient in the event of an untoward event. Those same offices contact MAA to share and obtain additional information. The Office on Emergency Management is accountable for

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dissemination of planned information as it relates to Critical events (e.g. - Hurricanes, Bio-Terrorist actions, natural Disasters) etc.
 MAA-ODA evaluates each critical or unusual incident report on a case by case basis following up by telephone and or visit based upon the reported event. Events are referred to the appropriate clinical staff for validation and reported event specifics. Once received appropriate action is determined including investigation, findings and upon final review potential sanctions.

- d. 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.

The DOH/MAA-Office on Disabilities and Aging uses the District Office on Emergency Management (OEM) and the Department of Health (DOH) Emergency Health and Medical Services Administration (EHMSA) to gather important disaster information that may affect waiver participants. EHMSA communicates plans with each District Department and Administration on a quarterly basis with emergency response broadcasts and related emergency information. Critical incidents such as Hurricanes or blizzards that may affect waiver participants are shared with DOH by EHMSA. MAA-ODA contacts each EPD case management agency who in turn contacts participant with updates or alerts, as needed. A Master database list is also maintained and updated by MAA-ODA to enable MAA-ODA to track who has been contacted or to further share critical incident information.

The important information that may affect EPD Waiver participant is collected by those District management agencies identified above for critical incidents and natural disasters.

RE: Unusual incidents:

In addition, there is a requirement that each EPD Waiver provider must submit 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 MAA that includes the specifics of the accident or unusual incident. MAA-ODA 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. MAA 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 MAA and HRA 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 MAA Office of Program Integrity, Medicaid Fraud and Control Unit of the Inspector General, as needed. If the incident or event is properly addressed MAA 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.

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Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when the use of restraints and/or restrictive interventions is permitted during the course of the provision of waiver services regardless of setting. When a state prohibits the use of restraints and/or restrictive interventions during the provision of waiver services, this Appendix does not need to be completed except for Item G-2-c-ii.

a. Applicability. Select one:

<input checked="" type="checkbox"/>	This Appendix is not applicable. The State does not permit or prohibits the use of restraints or restrictive interventions (<i>complete only Item G-2-c-ii</i>)
<input type="checkbox"/>	This Appendix applies. Check each that applies:
<input type="checkbox"/>	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. <i>Complete item G-2-b.</i>
<input type="checkbox"/>	Services furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. <i>Complete item G-2-c.</i>

b. Safeguards Concerning Use of Restraints or Seclusion

- i. Safeguards Concerning the Use of Restraints or Seclusion.** 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 or 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).

N/A

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

N/A

c. Safeguards Concerning the Use of Restrictive Interventions

- 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.

N/A

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- 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:

The District has specific regulations on the use of physical and chemical restraints that are consistent with or more stringent than federal law. The DOH Health Regulation Administration is responsible for oversight on the use of physical and chemical restraints. Their responsibility includes monitoring of facilities, primarily Nursing Homes and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR). These HRA regulatory surveys are conducted semi-annually, and as needed. The MAA- Quality Improvement Organization (Delmarva Foundation) also monitors use of restraints in Nursing Homes. MAA also coordinates with the Adult Protective Services (APS) to look at any instances of use of physical or chemical restraints among Waiver customers/Clients. MAA-ODA also works with District Long Term Care Ombudsman's Office to both gather and coordinate information on restrictive interventions in Long Term Care. The MAA also coordinates with the D.C. Office on Aging, where possible who gather and report on abuse and neglect in the community, and with the Medicaid Fraud and Abuse Office of the D.C. Inspector General's Office to report and follow-up as needed. The District MAA has recently begun efforts to work also with the LTC Ombudsman Office to provide more oversight of home and community based facilities on at least a semi-annual basis. Currently, such reviews are only done on a sampling basis by MAA-ODA annually. Most often this results in visits to ten percent of the Waiver participant. Given the increase in EPD Waiver customers it will be important to visit more homes to assess care and use of restrictive interventions.

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Appendix G-3: Medication Management and Administration

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:

<input type="radio"/>	Yes. This Appendix applies (<i>complete the remaining items</i>).
<input checked="" type="radio"/>	No. This Appendix is not applicable (<i>do not complete the remaining items</i>).

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.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

<input type="radio"/>	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. (<i>complete the remaining items</i>)
<input checked="" type="radio"/>	Not applicable (<i>do not complete the remaining items</i>)

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).

Waiver providers are not permitted to administer medicines.

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iii. Medication Error Reporting. *Select one of the following: N/A*

<input type="radio"/>	Providers that are responsible for medication administration are required to <i>both</i> record and report medication errors to a State agency (or agencies). <i>Complete the following three items:</i>
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to <i>record</i> :
	(c) Specify the types of medication errors that providers must <i>report</i> to the State:
<input type="radio"/>	Providers responsible for medication administration are required to <i>record</i> 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:

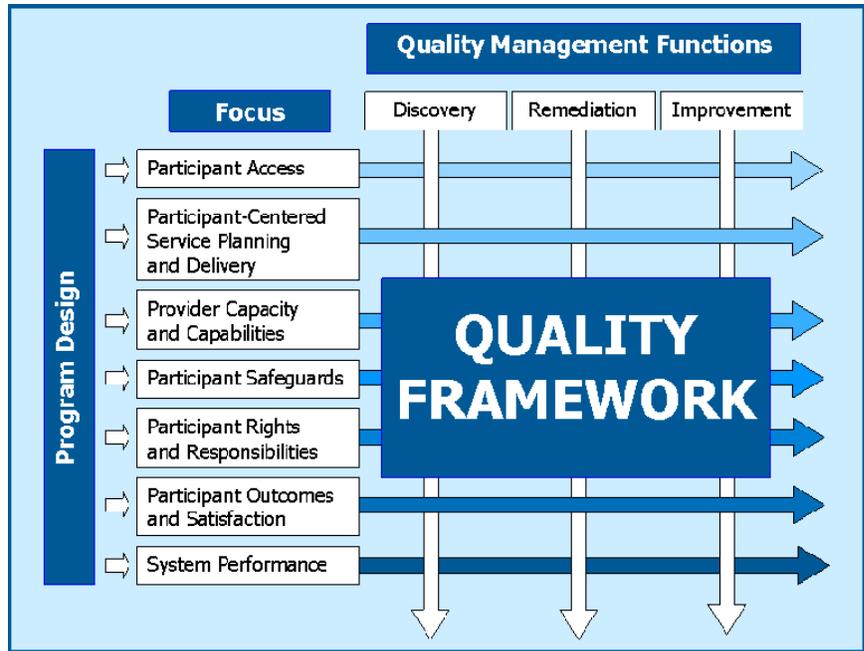
iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

N/A

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Appendix H: Quality Management Strategy

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 Management 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. A Quality Management Strategy explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state’s waiver Quality Management 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 Management 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 Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

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Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:

- Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
- The entities or individuals responsible for conducting the discovery/monitoring processes;
- The types of information used to measure performance; and,
- The frequency with which performance is measured.

2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.

3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*

4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*

5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy.**

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If the State's Quality Management 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 Management Strategy, including the specific tasks that the State plans to undertake during the period that 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 Management 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 identify the other long-term services that are addressed in the Quality Management Strategy.

APPENDIX H: QUALITY MANAGEMENT STRATEGY

District of Columbia Quality Management Strategy: Minimum Components Response:

The Quality Management Strategy that will be in effect during the period of the waiver included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency of the operating agency (if appropriate).

1. The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met. The applicable assurances and requirements are:
 - A. Level of care determination
 - B. Service Plan
 - C. Qualified providers
 - D. Health and welfare
 - E. Administrative and authority, and
 - F. Financial accountability

Each waiver assurance, this description must include:

- A. Activities or processes related to discovery, monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery.
- B. The entities or individuals responsible for conducting the discovery/monitoring processes
- C. The types of information used to measure performance and
- D. The frequency with which performance is measured

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The MAA-ODA conducts record reviews of the entire EPD population on an annual basis. ODA conducts quarterly statistical review of data reports on an aggregate basis looking at a statistical sampling of a minimum of ten percent of recipient records. Data is aggregated in terms of persons with disabilities and those that are 65 years of age or older across each of the six CMS assurance areas.

A. LEVEL OF CARE DETERMINATION

ASSURANCE	MONITORING ACTIVITY	MONITORING RESPONSIBILITIES	DATA/REPORTS	FREQUENCY	TIMELINES
Assessing the determinants that dictates the need for Long Term Care service is a required component of care.	All level of care approvals are performed by Delmarva, the Quality Improvement Organization (QIO).	QIO The levels of care and functional analysis of the client is approved by QIO MAA reviews LOC upon submission of the application for the EPD Waiver	Continuous Quality Improvement Report 1728 Form upon submission	Monthly reports are generated by QIO	Ongoing
Level of Care determination Process	<ul style="list-style-type: none"> • The LOC form the 1728 sent approval to ODA from QIO • Referral form to ODA with admission documents 	QIO-Delmarva Case Manager ODA staff	CQI reports-ODA LOC FORM 1728	Quarterly	On-going
		Admission records	A review of 10% or 30 records CQI Report Review of IADL & ADL	Quarterly On admission	On-going
Enrolled participants	Re-evaluation of Level of Care	ODA Agency Case Manager/ Agency1	Recertification Log	Monthly/ODA	Every 12 months
LOC decisions	Accurate LOC	QIO-Delmarva ODA-	Review of LOC Review of Denials	Monthly Monthly	Ongoing
Quality indicators	<ul style="list-style-type: none"> • Submission of LOC upon initial and annual assessment • Timeliness of LOC • Approval of LOC by QIO • Appropriateness of IADL 	MAA/ODA	CQI Report	Quarterly Annual	On-going

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B. SERVICE PLAN

ASSURANCE	MONITORING ACTIVITY	MONITORING RESPONSIBILITIES	DATA/REPORTS	FREQUENCY	TIMELINES
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.	Individual Service Plan reviewed	<ul style="list-style-type: none"> • The Office on Disabilities and Aging • Case Manager / Agency 	Continuous Quality Improvement Report (ODA)	Quarterly reports	Ongoing
	Monitors service plan in accordance with its policies and procedures and takes action with inadequacies	<ul style="list-style-type: none"> • Case Manager/Agency • ODA staff 	Data Review of ISP for each participant CQI report for quarterly monitoring	Admission Chart review Admission Chart annually	Ongoing
Service plans are updated/revise d at least annually or when warranted by changes in waiver participants needs	ISP submitted upon annual recertification	<ul style="list-style-type: none"> • Case manager • ODA staff manager 			
Choice of providers Home vs. Institutionalization	Documentation of Choice for Participant	<ul style="list-style-type: none"> • ODA • Case Manager/Agency 	<ul style="list-style-type: none"> • CQI Report • Beneficiary Freedom of Choice Signed 	Quarterly Chart review on admission	Ongoing
Client Health 4205.4 (M)	Review of <ul style="list-style-type: none"> •Health •Medications •Hospitalization •Infections •Wounds •Falls •Transportation 	<ul style="list-style-type: none"> • ODA • Case Manager/ Agency 	<ul style="list-style-type: none"> • Continuous Quality Improvement Report 	Quarterly	Ongoing
			<ul style="list-style-type: none"> • Initial admission chart • Change 	Ongoing	Ongoing

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			Request		
Quality Indicators	<ul style="list-style-type: none"> •Hospitalization •Infections •Falls •Wounds •Client Signatures •PCA, Case Management Service •RN Visits 	<ul style="list-style-type: none"> • ODA • Case Manager • RN Visits 	<ul style="list-style-type: none"> • Continuous Quality Improvement Report • Documented on client Health Form 	Quarterly Admission Monthly Visits Notes	Ongoing Admission Annual Chart Review by ODA Change request as needed

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C. QUALIFIED PROVIDERS

ASSURANCE	MONITORING ACTIVITY	MONITORING RESPONSIBILITES	DATA/REPORTS	FREQUENCY	TIMELINES
A Provider determined approval is according to the met compliance that each agency is able to show. Requirements are of the State Medicaid Agency as well as the Health and Licensure regulatory agencies. State verifies that providers meet required licensing and/or certification requirements 4215.1 (B)	Review all Provider Applications for compliance with required documentation and evidence of appropriate supports necessary for operations of Home Health Agencies. Agencies not meeting requirement are denied program approval	The Office on Disabilities and Aging [ODA] Public Health Analyst	Checklist of required document CQI Report Deficiency Report	As applications are submitted Annual	Ongoing
Complaints	Reviews all	ODA [PHA]	Complaints	As reports are	On-going

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submitted by provider	complaints, agency required to submit chronology of information		reviewed	submitted, ongoing Tabulated quarterly	
	Monitors Personnel records Agency licensing	ODA [PHA]	<ul style="list-style-type: none"> On-site review of licensing/ records Personnel records 	Reported Quarterly on CQI	Annual
	Monitoring training (12 hrs.) requirement for direct care staff	ODA Agency DON	<ul style="list-style-type: none"> On-site review of personnel training records Deficiency Reports 	Reported Quarterly On CQI	Annual visit
Quality Indicators	<ul style="list-style-type: none"> Provider licensures Personnel files and training certificates Annual 12 hrs. training in Personnel files <p>Note:</p> <p>Agencies who do not have approved business license cannot provide services in conjunction with the District</p> <p>Agencies found to have staff with false/ inappropriate staff must be dismissed or providers admission privilege held</p>	<ul style="list-style-type: none"> ODA Case Manager DON - Agency 	<ul style="list-style-type: none"> Continuous Quality Improvement Report Deficiency Reports 	Quarterly	Annual Correction necessary within 3 months

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D. HEALTH AND WELFARE- Participant Safeguard

ASSURANCE	MONITORING ACTIVITY	MONITORING RESPONSIBILITIES	DATA/REPORTS	FREQUENCY	TIMELINES
State Medicaid Agency seeks to identify and address all instances of abuse, neglect, and exploitation	All complaints that reference abuse, neglect, exploitation, agencies are requested to submit a complete factual report	<ul style="list-style-type: none"> • ODA/MAA • Case Manager Agency 	Continuous Quality Improvement Report Complaint documents	Quarterly reports are generated	Ongoing Immediate
Coordination of services is necessary to ensure that welfare and needs are met	Review all coordination of services	<ul style="list-style-type: none"> • ODA • Case Manager/Agency • RN/Agency 	<ul style="list-style-type: none"> • Data Review of ISP for each participants • CQI report for quarterly monitoring 	Daily chart review of admissions Quarterly	On-going
	Assess overall health and welfare of customer by reviewing ISP	ODA	<ul style="list-style-type: none"> • Customer Satisfaction Survey tool • Home visit tools 	Quarterly	Ongoing Annual
	Identify perceived risk as reported from ISP Plan Conduct risk assessments	<ul style="list-style-type: none"> • Case manager • ODA Staff 	<ul style="list-style-type: none"> • Falls Number • Wounds Number • (Medication errors effective upon implementation of assisted living) • Infections Number • Skin Breaks Number • Summary and analyses of all risks and assessments 	<ul style="list-style-type: none"> •Ongoing •Quarterly •Quarterly 	Begin January 2007
Mitigation	<ul style="list-style-type: none"> • Review trigger matrix 	<ul style="list-style-type: none"> • Case manager • ODA staff 	<ul style="list-style-type: none"> • Risk assessment tool • Trigger matrix 	<ul style="list-style-type: none"> •On admission •Ongoing 	Begin January 2007
Quality Indicators	<ul style="list-style-type: none"> •Complaints • Infections developed 	<ul style="list-style-type: none"> • ODA • Case Manager/Agency 	<ul style="list-style-type: none"> • CQI Report • Customer satisfaction 	<ul style="list-style-type: none"> • Quarterly 	Ongoing

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	<ul style="list-style-type: none"> • Wounds Worsening non-healing • Unaccounted for bone breaks • Falls • Bruises unaccounted • No service • Poor service 	<ul style="list-style-type: none"> • RN Agency 	reports		
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NOTES: Reports of abuse, neglect, and exploitation are reported to the appropriate authorities.

Staff abuse, neglect – All Home Health agencies must report to MAA and submit corrective action plan which must include a thorough investigation.

Self neglect - Environmental, family, the Office for Adult Protective services is called to investigate.

Staff exploitation - The proper Law Enforcement Authorities are called in to address the concerns. As well as the Home Health agency corrective action plan.
 (e.g. - Theft)

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E. ADMINISTRATIVE AUTHORITY

ASSURANCE	MONITORING ACTIVITY	MONITORING RESPONSIBILITIES	DATA/REPORTS	FREQUENCY	TIMELINES
State Medicaid Agency conducts routine, ongoing oversight of the waiver program	Review of claims report	Office on Budget and Finance	Budget Finance report 372 report	Monthly Annual	Ongoing
	Review of expenditures of Home Health Agencies	ODA	CSR from MMIS 372 report	Monthly review of two different Agencies Annually	On-going

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	Review of Waiver Audits	ODA	<p>Review of admission information , complaints, provision of services, review of satisfaction survey responses.</p> <p>Documentation on Recertification's for Level of Care.</p> <p>Beneficiary Freedom of Choice form ISP's</p> <p>CQI report</p> <p>Review of [all] level of care determination to assess the referral source for the recipient</p> <p>Review of sample population 10% of total for time taken from approval to actual provision of service.</p> <p>Admission documentation review sheet assess the referral source</p> <p>Conduct Monitoring site visits/review of <u>all</u> agencies</p> <p>Develop deficiency reports from monitoring visits request corrective action plan</p> <p>Review of all corrective actions plans</p> <p>Review of the ISP to ensure development by Interdisciplinary team</p> <p>Review of Case Managers caseload log</p> <p>Reviews QA plan of each agency</p>	<p>Quarterly</p> <p>Quarterly</p> <p>Quarterly</p> <p>Annual</p> <p>Admission Quarterly</p> <p>Quarterly Annually</p> <p>Annually</p> <p>Annually</p> <p>Annual</p> <p>Quarterly</p> <p>Annually</p> <p>Quarterly</p>	<p>Ongoing</p> <p>Ongoing</p> <p>Annual</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>
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The State maintains ultimate authority and responsibilities for operation of the waiver functions solely. However, the State Health Licensure and Regulatory authority are responsible for the performance of requirements for licensure. Therefore, sanctions may be administered by both agencies in conjunction with unmet compliance issues.

The Department of Health Medical Assistance Administration
 Office on Disabilities and Aging
 Appendix: H Quality Management Strategy

F. FINANCIAL ACCOUNTABILITY

ASSURANCE	MONITORING ACTIVITY	MONITORING RESPONSIBILITIES	DATA/REPORTS	FREQUENCY	TIMELINES
State Medicaid Agency conducts routine, review of expenditures and claims to ensure that all claims are coded and paid in accordance with the reimbursement methodology in an approved waiver	Monitoring of Claims from ACS Government Health Care Solutions	<ul style="list-style-type: none"> • ACS/Program Operations • ODA • SURS 	Claims reports Reviews total expenditures for a six month period [ODA] High Volume High Cost Problem Prone Cases	Monthly two different Home Health Agencies Reviewed	Ongoing
	Review of expenditures of Home Health Agencies	<ul style="list-style-type: none"> • ODA • Surveillance (SURS) as requested by ODA 	Expenditure data As needed to SURS 372 report	Monthly review of two different agencies	On-going
	Review expenditures for codes of EPD waiver participants	ODA	372 reports Review Exception reports as needed Claims details Report to SURS as needed	Annual As Needed	Ongoing
ISP cost sheet s are appropriate services at rates approved	Service Plan review of admission cost sheet of each new participant to waiver	<ul style="list-style-type: none"> • ODA (Final) • Case Manager 	Cost Sheet request in admission packet	On admission On change of service On recertification	Ongoing
Claims are billed according to ISP (cost sheet)	Claims Review	<ul style="list-style-type: none"> • ODA • Surveillance Utilization Review (SURS) 	Claims Report ODA report as needed	Monthly review of two Home Health Agencies for claims cost of numbered participant select at least 5 participants to	Monthly

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				assess cost	
Quality Indicators	<ul style="list-style-type: none"> • Cost of participant services • Number of participants billed for • Services billed vs. services approved 	<ul style="list-style-type: none"> • Claims report • ISP Cost Sheet 	AD-HOC Report ODA report as needed	Monthly	Ongoing
State Financial oversight for the fiscal management system claims are paid in accordance with the reimbursement methodology	Audits of claims and reconciliation of submission and denials.	<ul style="list-style-type: none"> • Provider • SURS 	Claims Data reviewed ODA reports as needed	Quarterly	Ongoing
	Review of Expenditures/cost overruns	<ul style="list-style-type: none"> • ODA 	Claims Data - Expenditures Reports Cost Reports	Quarterly	On-going

2. The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix waiver participations, advocates, and service providers.

District of Columbia ROLES AND RESPONSIBILITIES;

- Public Health Analyst of the Office on Disabilities and Aging [ODA] collect and review the admission application for entrance into the waiver program
- Assessment of the collective information on the applications received using specific indicators as outline for quarter.
- Case Managers are responsible for the coordination of services and review of the overall effectiveness of the services
- ACS represents the Fiscal Intermediately ultimately collates the claims and assign the claims respective dollar amount

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- Surveillance Utilization and Review System [SURS] is responsible for assigning utilization review of claims and ultimately ascertaining if over utilization was realized. The agency recoups money for overpaid services.
- ODA is assigned the monitoring of deficiencies for the Home Health Agencies and the issuing of sanctions

3. Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.

The following processes, priorities and strategies are used:

- To identify the important aspect of care upon which the staff should focus is on the review of problem prone, high dollar [cost] of the participants services
- Outcomes and appropriateness of home health aide and personal care services as outlined in the plan of care is accomplished by reviewing the supervisory notes on an annual audit
- Coordination of care by the case managers is reviewed by the ODA staff on admission, and upon recertification of the participant
- Priorities for reviews are based on the indicators which are identified on a annual basis
- Utilization of services are monitored according to the cost and any outliers are referred to the SURS unit
- Deficiency reports are issued to all agencies found not to be in compliance with the rules. Corrective action plans are required for all deficiencies recorded at the annual visits.
- All deficiencies found in the admission and /or recertification documents submitted to ODA are returned to the sender with a checklist identifying the issues found.
- Remediation are conducted as educational sessions during the quarterly meetings, one on one sessions with case managers, and sample documents formatted with appropriate information are disseminated to those who need assistance with the processes. Included with each new provider training we issue:
 - CD with all ODA required EPD forms,
 - sample documents with appropriate information [templates]
 - instructions on the use of the documents.

4. The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information [in report or other forms] to waiver participants, families, waiver services providers, other interested parties, and the public.

MAA- ODA Quality Improvement committee convenes quarterly meetings with stakeholders of the Medicaid Waiver program for Elderly and Persons with Physical Disabilities. The agency providers, community members and other stakeholders meet to discuss as well as mitigate the issues. MAA staff shares information with this group on quality issues related to service provision, complaints, implementation of Medicaid Waiver Service and service delivery.

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The following information is communicated with clients, Waiver providers, interested parties and the public:

- Quarterly the staff collects data relative to the identified indicators from the clients served during the quarter. The data is tabulated to show the overall rate of compliance, and the results are sent to the Chief.
- Indicators are identified based on occurrences that are outliers. Such as wound development, infections, complaints, Beneficiary freedom of Choice forms signature on all form and client satisfaction with direct care workers, case managers, agency providers.
- Reports are submitted on an annual basis and as requested by the community.
- Quarterly indicators that are considered problematic, are reviewed with the quality improvement committee quarterly
- Quarterly a Quality Improvement Report is generated and noted deficiencies are outlined in the report to management.

INDICATORS USED FOR MONITORING -QUARTERLY

The following indicators are used for monitoring on a quarterly basis:

- The quality of documentation
- The compliance with the plan of care as it relates to the diagnosis and actual care rendered
- Appropriateness and accuracy of the frequency and duration of visits
- Incident reporting which evaluated the prevalence of falls, incidence of new fractures, adverse drug reactions, prevalence of symptoms of depression, and incidents resulting in hospitalization of the client.
- Infection control
- Development of Decubiti Ulcers during the provision of care
- Compliance with wound protocol
- Client satisfaction with services rendered
- Supervision of direct care staff
- Client abuse and neglect
- Training and certification of providers
- Sentinel events including death
- Billing/claims processing
- Discharge audits, monitoring visits
- Utilization of services
- Patient Safety

5. The Quality Management strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategies.

The Quality Management plan is reviewed annually and revised as necessary. The quarterly reports are instrumental in identifying the needed improvements in the Quality Management

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plan. The data collected is on the identified indicators reviewed (quarterly) during the year. The data is used to systematically identify the needed improvements.

We review the following:

- Overall goals, objectives, outcomes
- Statewide reports which identify the quarterly trends in the various indicators
- Deficiencies noted on the provider monitoring site visits
- At least three of the indicators which are consistently high volume, problem prone, and high cost are the focus of the trending
- Sample populations are ten percent [10%] of the total
- Data collection is quarterly
- Key indicators are reviewed and national healthcare associations data banks are researched to ascertain benchmarks, trends and suggestions for remediation plans of identified deficiencies
- CMS regional or area wide information and/or requirement.

MAA- ODA Quality Improvement committee convenes quarterly meetings with stakeholders of the Medicaid Waiver program for Elderly and Persons with Physical Disabilities. The agency providers, community members and other stakeholders meet to discuss as well as mitigate the issues. The quarterly meetings are also triggers to revision of Quality Improvement program plan.

Identification of practices, utilization of service trends, adverse statistical profiles in service delivery, inappropriate corrective action plans, complaints, risk mitigations, and participants emergency plans, are all outcomes used to revise and update the Quality Improvement Management Plan.

The assurances as outlined by the Centers for Medicare and Medicaid services are specific in their guidelines; the needed service modifications will be reflected in the Services rules as well as the service documentation and the Quality Improvement Plans.

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Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

The Quality Management Strategy noted as the continuous quality improvement program consists of ongoing process improvement activities and includes periodic sampling of activities not limited solely in response to an identified problem.

Monitoring activities reflect key specific agency functions, services and activities that are the agencies focus. The monitoring activities of identified indicators are evaluated Quarterly. They are re-evaluated and revised as necessary.

ODA will:

- Collect, screen and evaluate information to identify opportunities to improve
- Track, trend and resolve problems in participants care, services and customer satisfaction
- All service plans for each participant will reflect current problems, interventions, risk assessment, mitigation of risks and goals that respond to the care and appropriateness of services
- State and federal requirements will also be maintained
- Participants will be included in development of plans for services and emergencies
- Confidentiality of information will be ensured for all participants
- Key aspects on participants will be identified and serve as the focus of ongoing monitoring, aspects of care and services monitored will be prioritized as high risk, high volume, and problem prone
- Selection of indicators will be based on delivery of care in the home, staff performance, changes in the participant's activities of behavior etc. ADL, complaints and provision of services
- Reasonable measures will be utilized to determine effectiveness as well as appropriateness of services
- Evaluation of findings through data analysis and established benchmarks will be conducted. Quarterly CQI reports are formulated on identified aspects
- Data collection will not be limited but will reflect satisfaction survey, direct observation as well as record reviews
- Methods used to identify/report will be flow charts, cause and effect diagrams, praetor charts, and control charts, etc.

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Appendix I: Financial Accountability

APPENDIX 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).

Claims for the EPD waiver services are based on approved services that have been rendered to waiver participants, authorized in the service plan and billed by the appropriate agency representative. Independent audits here to fore have not been required. However, the Office of the Inspector General conducts audits, as indicated. To monitor the financial billing of the agencies, monthly claims are available from the fiscal intermediary, currently ACS Government Healthcare Solutions. All claims must be requested.

Monitoring: The Medical Assistance Administration fiscal intermediary monthly tabulates the expenditures of each agency.

1. The Office on Disabilities and Aging reviews each recipient cost of services at the initial service request and during change of service request.
2. ODA reviews at least two agencies. All claims/expenditures monthly request are made of ACS at the beginning of each month. Indices of services on claims reviewed are:
 - Unduplicated participant
 - Average payment per recipient
 - Claims count
 - Total sum service
3. Agencies reporting high dollar expenditure and low numbers of participants are sent to MAA Surveillance and Utilization Review System (SURS). Additional triggers for review would be:
 - Providers whose acuity fall outside of the norm (exceptional file)
 - Referrals based recipient complains
 - Hospitalization claims of EPD Waiver participant
4. State submits annual CMS 372/373 reports
5. Chapter 42 of title 29 of the District of Columbia Municipal Regulations (DCMR) entitled “Home and Community-based Waiver Services for Persons who are Elderly and Individuals with Physical Disabilities”, are rules established standard governing reimbursement by the District of Columbia. These rules are available to the Public.

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APPENDIX I-2: Rates, Billing and Claims

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rate Methodologies for the MAA-Office on Disabilities and Aging – November 2006

The District of Columbia MAA Office of Audit and Finance is responsible for all rate development with the assistance of program staff from the Office on Disabilities and Aging. Together, MAA staff develops rates for each EPD waiver service. The rate information is available to participants upon request and is available on the www.adrcdc.org website. The rate process includes market analysis as well as:

1. A review of rate structure and methodology in surrounding jurisdictions: (Maryland and Virginia) is conducted
2. Meetings are held with providers and community stakeholders to assess any outstanding issues as well as provide information and receive clear understanding of community needs and concerns
3. Meetings held with DC Council and DC Council Long Term Care Task Force to discuss rates and rate structure as rates for direct care workers (Personal Care Aide (PCA) and Home Health Aide (HHA))
4. A review and comparison of prevailing rates for specific services is offered under the state plan benefits.
5. A review and assessment of expertise and capacity of providers and services.
6. Rate information for Medicaid participants and community members is provided on-line through the www-adrcdc.org website.
7. Transmittal Letters from the MAA Director are sent to each provider indicating any changes or modifications in rates and rate structure.

With the aforementioned rate structure identified the Elderly and Persons with Physical Disabilities Waiver service rates are determined based on a geographic market analysis. This includes review of service providers across the District of Columbia, Suburban Maryland and Northern Virginia within each of the nine Waiver services. Each service is reviewed and compared to providers offering services in surrounding jurisdictions and to geographic differences and provider supply. There is no automatic inflation increase. In January 2006 direct care worker rates, (not nursing) were adjusted to provide a more 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. A review of the industry indicated that there was significant turnover of workers based on low wages and no benefits. This information was also factored into the rate increase.

Personal care aides who work within the Waiver are paid on an hourly basis at a rate of \$16.30. The most recent rate of \$13.50 was recognized as inadequate in the District by providers, advocates and workers as this was a facility rate of which the worker received between \$8-10.00 per hour. Worker turnover was high and demand was increasing. MAA saw this as a quality of care issue. Added to this, District legislators moved to impose District living wage legislation. There is not a

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set methodology for determining rate increases. Rates are increased when MAA determines that it is needed to assure an adequate provider supply and customer continuity of care is compromised. Because of a concern that the provider supply is inadequate, MAA has increased the rate from \$13.50/hour to \$16.50/hour to better reflect a living wage. This increase allowed providers to ensure payment to workers of at least \$10.50/ hour and still cover administrative costs and payroll taxes.

- 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:

DESCRIPTION OF THE BILLING PROCESS

The District Medicaid Management Information System is operated by a CMS approved external Fiscal Intermediary (FI). This FI is responsible for the operation of the MMIS system and the claims payment system that uses HIPAA compliant codes. The company providing these FI services is entitled Affiliated Computer Services (ACS). ACS has a District Office designed to allow staff to work directly with MAA to address any concerns on a daily basis regarding claims as well as claims details. Billing is paid out on a regular payment schedule for electronic claims of every two weeks for routine fee for service provider claims, slightly longer for paper check claims and mailings, and on a case by case basis for special claims. ACS normally processes all claims made under the home and community-based care EPD waiver every two weeks. ACS also enlists an ACS community representative to work with MAA-ODA to address EPD Waiver provider and billing issues and offer training to address payment questions and provide detailed information. MAA staff receives training on how to best use the MMIS system to review claims.

- c. Certifying Public Expenditures (select one):**

<input type="radio"/>	Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (<i>check each that applies</i>):
<input type="checkbox"/>	Certified Public Expenditures (CPE) of State Public Agencies. Specify: (a) the public 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). (<i>Indicate source of revenue for CPEs in Item I-4-a.</i>)
<input type="checkbox"/>	Certified Public Expenditures (CPE) of Non-State Public Agencies. Specify: (a) the non-State public 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). (<i>Indicate source of revenue for CPEs in Item I-4-b.</i>)

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X	No. Public agencies do not certify expenditures for waiver services.
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- 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:

The CMS approved MMIS will be used to process all claims made under the home and community-based care waiver. This system is currently operated by a fiscal intermediary, ACS Government Healthcare Solutions.

In order to assure that waiver services are reimbursed only when the services were required by the Individual Support Plan, MAA will forward key service components to the office of Information Systems of ACS (Fiscal Intermediary) which will input the covered services into the system within 10 days of receipt of the electronic Prior Authorization. MAA must forward the information to ACS, the Fiscal Intermediary within 3 months of receipt. Prior to payment of a claim, the system will cross check the date and type of service with those specified in the ISP.

Eligibility of a beneficiary is verified monthly before each claim is paid. The Income Maintenance Administration, Bureau of Program Operations is responsible for evaluating the eligibility of each Medicaid applicant on a recurring basis, as described in the State Plan, Attachment 4.22-A. Those individuals presenting an 853 waiver code are verified as eligible on specified date.

Service date start of care is important for approved implementation of service, but may differ from ISP SOC due to ineligibility at the time. Start of care dates are adjusted to actual implementation. Billing does not start until implementation. Services are validated through several methods:

1. Calls to agencies to ascertain start of care
2. Calls to participants to validate if services were started
3. Validation of time and attendance sheets
4. Within 2 months from implementation of the renewal of this waiver several agencies will validate services implementation through an electronic telephone system
5. Case managers visit notes
6. Supervisor RN notes

- 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 §74.53.

MAA-ODA conducts approximately fifty claims reviews monthly.

The billing forms must be supported with adequate documentation by the provider. Each provider must maintain records including at a minimum:

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- Date, time, location of the provision of service
- Prior Authorization form
- Patient identification information (Name, ID Number, Sex, Date of Birth)
- The documentation maintained by MAA should include at a minimum:
- A copy of the Individual Support Plan (ISP)
- A current medical record which should contain any notes, prescriptions, or referrals by a physician or other provider (such as a physical therapist, personal care aide, etc.)
- Each service provided to the customer should be recorded by the provider, at least including the date of service and length of time
- Results of any tests (laboratory, diagnostic, psychological evaluations) should be included in the medical record
- Relevant Financial Records
- Notice of Eligibility Determination

Documentation that must be forwarded to the fiscal intermediary:

- Summary sheet from ISP designating exact services the beneficiary is eligible for, and frequency and duration prescribed for the services
- Listing of approved providers with provider numbers
- Billing forms with information as described above
- Additional information required to process claims, such as financial eligibility status, will be handled through the Income Maintenance Administration.

Chapter 42 – Title 29 DCMR, 4206 - Access to records

4201.1 Each provider of waiver services shall allow access to a recipient’s record during announced or unannounced audits or reviews by designated MAA staff and federal representatives as set forth in 4237.3 and 4237.4 of this Chapter.

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APPENDIX I-3: Payment

a. Method of payments — MMIS (*select one*):

<input checked="" type="checkbox"/>	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
<input type="checkbox"/>	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) 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.
<input type="checkbox"/>	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:
<input type="checkbox"/>	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:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements (*check each that applies*):

<input checked="" type="checkbox"/>	The Medicaid agency makes payments directly to providers of waiver services.
<input type="checkbox"/>	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
<input type="checkbox"/>	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:
<input type="checkbox"/>	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.

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- 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:*

<input checked="" type="radio"/>	No. The State does not make supplemental or enhanced payments for waiver services.
<input type="radio"/>	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 and (b) the types of providers to which such payments are made. 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.

- d. Payments to Public Providers.** *Specify whether public providers receive payment for the provision of waiver services.*

<input type="radio"/>	Yes. Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. <i>Complete item I-3-e.</i>
<input checked="" type="radio"/>	No. Public providers do not receive payment for waiver services. <i>Do not complete Item I-3-e.</i>

- e. Amount of Payment to Public Providers.** Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

<input type="radio"/>	The amount paid to public providers is the same as the amount paid to private providers of the same service.
<input type="radio"/>	The amount paid to public 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.
<input type="radio"/>	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public 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:

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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:*

<input checked="" type="radio"/>	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
<input type="radio"/>	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
<input type="radio"/>	Providers are paid by a managed care entity (or entities) that are paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

<input type="radio"/>	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.
<input checked="" type="radio"/>	No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

<input type="radio"/>	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:
<input checked="" type="radio"/>	No. The State does not employ Organized Health Care Delivery System (OHCDs) arrangements under the provisions of 42 CFR §447.10.

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iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

<input type="radio"/>	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 <i>voluntarily</i> elect to receive <i>waiver</i> 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.
<input type="radio"/>	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain <i>waiver</i> 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.
<input checked="" type="radio"/>	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

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APPENDIX I-4: Non-Federal Matching Funds

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. *Check each that applies:*

<input type="checkbox"/>	Appropriation of State Tax Revenues to the State Medicaid agency
<input type="checkbox"/>	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 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 public agencies as CPEs, as indicated in Item I-2-c:
<input type="checkbox"/>	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 public agencies as CPEs, as indicated in Item I-2- c:

b. Local 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. *Check each that applies:*

<input type="checkbox"/>	Appropriation of Local Revenues. Specify: (a) the local 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 public agencies as CPEs, as specified in Item I-2- c:
<input type="checkbox"/>	Other non-State Level Source(s) of Funds. Specify: (a) the source of funds; (b) the 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 public agencies as CPEs, as specified in Item I-2- c:
<input checked="" type="checkbox"/>	Not Applicable. There are no non-State level sources of funds for the non-federal share.

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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. *Check each that applies.*

<input type="checkbox"/>	Provider taxes or fees
<input type="checkbox"/>	Provider donations
<input type="checkbox"/>	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
<input checked="" type="checkbox"/>	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

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APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

<input type="radio"/>	No services under this waiver are furnished in residential settings other than the private residence of the individual. <i>(Do not complete Item I-5-b).</i>
<input checked="" type="radio"/>	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. <i>(Complete Item I-5-b)</i>

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 MAA 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 MAA. 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

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- 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) Homemaker;
 - (c) Chore Aide;
 - (d) Therapeutic social and recreational services

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APPENDIX 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:

<input type="radio"/>	<p>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. <i>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:</i></p> <div style="background-color: #cccccc; height: 50px; margin-top: 5px;"></div>
<input checked="" type="radio"/>	<p>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.</p>

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APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

- a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

<input checked="" type="checkbox"/>	No. The State does not impose a co-payment or similar charge upon participants for waiver services. <i>(Do not complete the remaining items; proceed to Item I-7-b).</i>
<input type="checkbox"/>	Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services. <i>(Complete the remaining items)</i>

- i. Co-Pay Arrangement** Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies):*

<i>Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):</i>	
<input type="checkbox"/>	Nominal deductible
<input type="checkbox"/>	Coinsurance
<input type="checkbox"/>	Co-Payment
<input type="checkbox"/>	Other charge <i>(specify):</i>

- ii. Participants Subject to Co-pay Charges for Waiver Services.** Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

- iii. Amount of Co-Pay Charges for Waiver Services.** In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

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iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (*select one*):

<input type="radio"/>	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
<input type="radio"/>	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

<input checked="" type="checkbox"/>	No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
<input type="checkbox"/>	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 as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Factor G includes both in District and Out of State Nursing Facility costs.

Level(s) of Care (<i>specify</i>):			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 (Column 7 less Column 4)
1	6224.91	27,403.00	33,627.90	49,795.00	3,803.00	53,598.00	19,970.10
2	6444.31	30,143.00	36,587.31	54,774.00	4,183.00	58,957.00	22,369.69
3	6582.61	33,157.00	39,739.61	60,251.00	4,601.00	64,852.00	25,112.39
4	6546.20	37,467.00	44,013.20	68,083.00	5,199.00	73,282.00	29,268.80
5	6520.95	41,213.00	47,733.95	74,891.00	5,718.00	80,609.00	32,875.05

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Appendix J-2 - Derivation of Estimates

- 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:	Level of Care:
		NF	
Year 1	1,700		
Year 2	1,940		
Year 3	2,180		
Year 4 (renewal only)	2,420		
Year 5 (renewal only)	2,660		

- 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-d.

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 December 2006. The District took the total number of enrolled days divided by total number of participants.

- 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:

The District calculated this information for the J-2-d tables using the following experience and assumptions: The District used the most recent CMS 372 information and looked back over the past four years of 372 reports for historical trends. The District then calculated actual number of users and then divided the actual number by the units of service across each of the seven waiver services for the Waiver year. This included respite which is an EPD waiver service. The District trended this information forward looking at potential increases in cost based on Market Basket Index of 3.1% or overall 4.7% growth. There is no inflation factor offered. However, there is a one time proposed increase in worker rates in year three percent (3%).

The District also used a picture date of January 2006 and January 2007 to compare increase. The District further estimated growth in numbers of participants and projected increased utilization overall of approximately ten percent (10%). The District anticipated increase in enrollment of approximately ten percent per annum

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- 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:

The District derived these costs by estimating the average cost of care for all Medicaid State Plan services (including home health, personal care, adult day health care, short-term institutional care, hospitalization) furnished for the time period in which the individual would have been on the EPD waiver. The District did not include pharmacy drug costs for Medicare/Medicaid Dual-eligibles that are covered by newly implemented Medicare Part D (January 2006). The District did this by subtracting the premium paid per person to CMS for the Clawback multiplied by the number of EPD Waiver dual eligible persons. These numbers were supplied by the CMS approved District Medicaid Management Information System (MMIS) and reflected in the CMS 372 report.

Because this EPD Waiver application is a renewal application the trend appears to be a continued rise (as shown in the most recent CMS 372 report showing costs of approximately \$27,000 per person) or increase in the cost of care in the EPD Waiver due to higher utilization and increased enrollment. This will be due to more persons choosing Home and Community based Services (HCBS) as opposed to institutional care. Despite this increase in the cost of HCBS over the next five year period, the projected costs of HCBS care will remain less than institutional care.

- 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:

The District identified the average cost for levels of institutional care that would otherwise be furnished to waiver participants. The EPD Waiver utilizes a Nursing Home Level of Care (LOC) and so only the average LOC cost of Nursing Home care is utilized. Respite care is not included in the District's calculation for Factor G. The data reflects an estimate of the total cost of institutional services projected to be an increase of ten percent per year increase for each of the successive year. There will be some flattening of costs for Nursing Facility in part due to changes brought about by a new Nursing Facility Case Mix payment methodology instituted in January 2006.

Some people will be more expensive based on their acuity needs and some will be less expensive. The 372 costs for the first three years of the Waiver did not reflect this change as Nursing Facility Case Mix system was not in place. The District could not project or trend this information forward more than was estimated due to the fact that the District only has one year of historical Nursing Facility Case Mix data. However, if this one year is an indication of future need the net effect is expected to be that the costs for Nursing Home care will rise at about ten percent but not as great as the national average of approximately fourteen percent.

- 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:

The District derived Factor G' by including the cost of all other State plan services furnished while the individual was institutionalized. This included the cost of short-term hospitalization for those persons that were hospitalized and then return to the institution (Nursing Facility). This information was based solely on actual MMIS data and 372 Reports for each of the State Plan services furnished while in the institution (Nursing Facility) over the previous Waiver years. No Dual eligibles who received prescribed drugs were counted. The District subtracted the Duals' premium costs per person and multiplied this by the number of Dual eligible persons. Factor G' data began after the person's first day of institutional services.

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d. Estimate of Factor D. *Select one:* Note: Selection below is new.

<input checked="" type="checkbox"/>	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
<input type="checkbox"/>	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management Initial	Initial	141	1.00	500.00	70500.00
Homemaker	Hourly	20	3.00	10.00	600.00
Personal Care	15 min.	1700	1070.00	4.08	7421520.00
Respite, 1-17 hours	15 min	60	60.00	4.08	14688.00
Respite, 18-24 hours	Daily	20	10.00	300.00	60000.00
Case Management, Monthly	Monthly	1559	7.00	125.00	1364125.00
Case Management, Annual Re-assessment	Annual	693	1.00	225.00	155925.00
Personal Emergency, Initial	Initial	224	1.00	40.00	8960.00
Personal Emergency, Monthly	Monthly	405	8.00	28.50	92340.00
Assisted	Daily	71	233.00	60.00	992580.00
Environmental	Once	40	1.00	10000.00	400000.00
Chore Service	Hourly	25	3.00	15.00	1125.00
GRAND TOTAL:					10,582,363.00
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1,700
FACTOR D (Divide grand total by number of participants)					6224.91
AVERAGE LENGTH OF STAY ON THE WAIVER					232

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Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management, Initial	Initial	782	1.00	500.00	391000.00
Homemaker	Hourly	22	3.00	10.00	660.00
Personal Care	15 min	1940	1070.00	4.08	8469264.00
Respite, 1-17 hours	15 min	66	60.00	4.08	16156.80
Respite, 18-24 hours	Daily	22	10.00	300.00	66000.00
Case Management, Monthly	Monthly	1940	7.00	125.00	1697500.00
Case Management Annual Re-assessment	Annual	1158	1.00	225.00	260550.00
Personal Emergency, Initial	Initial	186	1.00	40.00	7440.00
Personal Emergency, Monthly	Monthly	446	8.00	28.50	101688.00
Assisted	Daily	78	233.00	60.00	1090440.00
Environmental	Once	40	1.00	10000.00	400,000.00
Chore Service	Hourly	28	3.00	15.00	1260.00
GRAND TOTAL:					12,501,959.80
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1,940
FACTOR D (Divide grand total by number of participants)					6444.31
AVERAGE LENGTH OF STAY ON THE WAIVER					233

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Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management Initial	Initial	860	1.00	515.50	443330.00
Homemaker	Hourly	24	3.00	10.31	742.32
Personal Care	15 min.	2180	1070.00	4.21	9820246.00
Respite, 1-17 hours	15 min.	73	60.00	4.21	18439.80
Respite, 18-24 hours	Daily	24	10.00	309.30	74232.00
Case Management	Monthly	2180	7.00	128.88	1966708.80
Case Management Re-assessment	Annual	1320	1.00	231.98	306213.60
Personal Emergency	Initial	205	1.00	41.24	8454.20
Personal Emergency	Monthly	519	8.00	29.38	121985.76
Assisted	Daily	85	233.00	60.00	1188300.00
Environmental	Once	40	1.00	10000.00	400000.00
Chore Service	Hourly	31	3.00	15.47	1438.71
GRAND TOTAL:					14,350,091.19
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					2,180
FACTOR D (Divide grand total by number of participants)					6582.61
AVERAGE LENGTH OF STAY ON THE WAIVER					234

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Waiver Year: Year 4 (renewal only)					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management, Initial	Initial	940	1.00	515.20	484570.00
Homemaker	Hourly	26	3.00	10.31	804.18
Personal Care	15 min.	2420	1070.00	4.21	10901374.00
Respite 1 – 17 hours	15 min.	80	60.00	4.21	20208.00
Respite, 18-24 hours	Daily	26	10.00	309.30	80418.00
Case Management, Monthly	Monthly	2420	7.00	128.88	2183227.20
Case Management, Annual Re-assessment	Annual	1480	1.00	231.98	343330.40
Personal Emergency, :Initial	Initial	224	1.00	41.24	9237.76
Personal Emergency, Monthly	Monthly	557	8.00	29.38	130917.28
Assisted	Daily	92	233.00	60.00	1286160.00
Environmental	Once	40	1.00	10000.00	400000.00
Chore Service	Hourly	34	3.00	15.47	1577.94
GRAND TOTAL:					15,841,825.00
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					2,420
FACTOR D (Divide grand total by number of participants)					6546.20
AVERAGE LENGTH OF STAY ON THE WAIVER					235

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Waiver Year: Year 5 (renewal only)					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Case Management, Initial	Initial	1,020	1	515.15	525453
Homemaker	Hourly	29	3.00	10.31	896.97
Personal Care	15 min	2660	1070.00	4.21	11982502.00
Respite, 1-17 hours	15 min	88	60.00	4.21	22228.80
Respite, 18-24 hours	Daily	29	10.00	309.30	89697.00
Case Management, Monthly	Monthly	2660	7.00	128.88	2399745.60
Case Management, Annual Re-assessment	Annual	1640	1.00	231.98	380447.20
Personal Emergency, Initial	Initial	243	1.00	41.24	10021.32
Personal Emergency, Monthly	Monthly	634	8.00	29.38	149015.36
Assisted	Daily	99	233.00	60.00	1384020.00
Environmental	Once	40	1.00	10000.00	400000.00
Chore Service	Hourly	37	3.00	15.47	1717.17
GRAND TOTAL:					17,345,774.46
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					2,660
FACTOR D (Divide grand total by number of participants)					6520.95
AVERAGE LENGTH OF STAY ON THE WAIVER					236

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UNDER-UTILIZATION OF SERVICES

The Homemaker service as outlined in the standards represent needed services for the residents who have need for housekeeping services beyond the scope of the Personal Care Aide. Personal care service is hands-on care but the homemaker service does not include hands-on care. General homemaker duties include housekeeping, errands, and laundry, as outlined. The EPD Waiver program's history has shown that most of the services needed by the EPD participants are for hands-on services as provided by the Personal Care Aide.

Provision of Respite care is for the families that are the primary care givers of the participant in the waiver program. Most of the participants in the program live alone therefore, the provision of services as outlined by the 24 four hours 20 day a year services has not been widely utilized. However, we have received more requests for the service in the current waiver year. MAA does anticipate a greater use of the service.

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