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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
The District of Columbia in the renewal of its1915 (c) Elderly and Physically Disabled (EPD) waiver plans to implement and operationalize participant-directed services during Waiver Year 2 to include the following participant-directed services: participant-directed goods and services and participant-directed personal care—that beneficiaries who choose to participant-direct may access. EPD Waiver participants may utilize the participant-directed option to exercise more choice and control over the management of their services and how those services are provided. The waiver also describes two new administrative activities that will be provided by a contracted entity and secured through a Request For Proposal (RFP) to support beneficiaries who choose to participant-direct. The Vendor Fiscal/Employer Agent (F/E A) FMS (Financial Management Services)/Supports Broker entity will operate under §3504 of the IRS code, Revenue Procedure 70-6 and 1/13/10 IRS Notice of Proposed Rulemaking for §3504 Agent Employment Tax Liability and DHCP Vendor F/EA and FMS Supports Brokerage requirements, and will offer counseling, information and assistance related to using participant-directed services and serving as the common law employer of their qualified direct workers, and will provide financial management services (i.e., fiscal, payroll and invoice processing and payment) to beneficiaries enrolled in the EPD waiver who choose to participant-direct and their representatives, as applicable.

The District is in the process of securing a CMS HCBS technical assistance contractor to get assistance with developing the required framework needed to operationalize Participant Directed Services and will submit an amendment upon completion of the policies and procedures needed to effect this services. In addition, as the District has already stated, it will be operationalizing participant directed services during Waiver Year 2 and DHCF will submit an amendment to the EPD Waiver application by June 30, 2012, to include the selection process for a Vendor F/EA Financial Management Services / Supports Brokerage entity.

The EPD waiver renewal also requests an increase of 2.78% of unduplicated waiver participants over the span of this five year waiver to reflect an increase of approximately 100 new unduplicated participants each year of the waiver. This increase has been requested to better accommodate the increasing current and anticipated community interest in and significant increased need for home and community based services. In addition, a further increase in the EPD Waiver numbers is needed to accommodate the D.C. Money Follows the Person Grant and anticipated age-outs from the Early Periodic Screening and Diagnostic Treatment (EPSDT) program.

The District has reserved capacity in the waiver renewal for two target groups – Money Follows the Person (MFP) participants and for beneficiaries aging out of the Early Periodic Screening Diagnosis, and Treatment (EPSDT) program. A total number of 55 slots will be available specifically for this group with 40 dedicated each year to MFP participants and 15 to the EPSDT age-outs.

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

1. Request Information (1 of 3)

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

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Elderly & Persons With Disabilities Waiver Renewal 01/04/2012

C. **Type of Request: renewal**

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

○ **3 years** ◉ **5 years**

☐ **Migration Waiver** - this is an existing approved waiver

☑ **Renewal of Waiver:**

Provide the information about the original waiver being renewed

Base Waiver Number: 0334

Amendment Number (if applicable):

Effective Date: *(mm/dd/yy)* 01/04/08

Waiver Number:DC.0334.R03.00
Draft ID: DC.003.03.00

Renewal Number: 03

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

Regular Waiver

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

01/04/12

Approved Effective Date: 01/04/12

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

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

NA

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

PURPOSE: The Elderly and Individuals with Physical Disabilities (EPD) Waiver serves individuals who are aged 65 and over, and the physically disabled population ages 18 – 64 in home and community-based settings, including assisted living facilities in lieu of nursing facilities.

GOAL: To ensure EPD populations with the provision of in-home supports will be able to reside in their homes with assistance attaining their activities of daily living.

OBJECTIVES:

Ensure the target population remains in home and community-based settings with supports
Enhance the quality of life for elderly and individuals with physical disabilities by preserving independence and relationships with family and friends
Expand the range of health care services for target population

ORGANIZATIONAL STRUCTURE: DLTC administers the waiver and its processes.

SERVICE DELIVERY METHODS: EPD waiver services have a defined population and specific rules outlining the implementation of services. Provider agencies enrolled by DHCF who serve EPD waiver recipients must complete the provider application, meet the waiver service requirements, and have a signed agreement with DHCF.
•The application and waiver rules are mandatory prior to rendering services and only after demonstrating capacity to meet criteria for the appropriate provision of services (home health agencies, case management agencies, and community service providers)
•The approved providers attend a mandatory orientation, including training to familiarize them with DHCF's electronic case management system, Casenet, which facilitates access to electronic forms and instructions for waiver services and providers receive technical assistance, as needed
•Providers receive a billing manual and an orientation to the billing process
•Provider case managers conduct participant assessments
•DHCF's Quality Improvement Organization determines participant level of care
•Beneficiary Freedom of Choice forms, Individual Service Plans, a Health History, and the Cost Sheets are completed by case managers and uploaded into Casenet
•The Economic Security Administration (ESA, formerly the Income Maintenance Administration/IMA) determines Medicaid eligibility and subsequently notifies applicants of program approval or denial
•All required documentation for the participant's service requests are sent to DLTC and reviewed for appropriateness of documentation, service approvals, and 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

Participant-Directed Services
The District of Columbia in the renewal of its1915 (c) Elderly and Physically Disabled (EPD) waiver plans to implement and operationalize participant-directed services during Waiver Year 2 to include the following participant-directed services: participant-directed goods and services and participant-directed personal care—that beneficiaries who choose to participant-direct may access. EPD Waiver participants may utilize the participant-directed option to exercise more choice and control over the management of their services and how those services are provided. The waiver also describes two new administrative services that will be provided by a contracted entity and secured through a Request For Proposal (RFP) to support beneficiaries who choose to participant-direct. The Vendor Fiscal/Employer Agent (F/E A) FMS (Financial Management Services)/Supports Broker entity will operate under §3504 of the IRS code, Revenue Procedure 70-6 and 1/13/10 IRS Notice of Proposed Rulemaking for §3504 Agent Employment Tax Liability and DHCP Vendor F/EA and FMS Supports Brokerage requirements, and will offer counseling, information and assistance related to using participant-directed services and serving as the common law employer of their qualified direct workers, and will provide financial management services (i.e., fiscal, payroll and invoice processing and payment) to beneficiaries enrolled in the EPD waiver who choose to participant-direct and their representatives, as applicable.

3. Components of the Waiver Request

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

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

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

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

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

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

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

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

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

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

1. Informed of any feasible alternatives under the waiver; and,

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

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

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

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

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

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation

and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
The public was requested to provide input and information on the development of the Waiver from its inception. Specifically, case managers, providers, and community advocates are invited to monthly EPD Waiver meetings. In the meetings the attendees were informed of the renewal process and continued services in the EPD Waiver The attendees were asked to forward any issues, concerns and or recommendations to DHCF/DLTC. Providers and Advocates were informed to provide feedback on the change to separate case management and direct care services.

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

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

7. Contact Person(s)

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

Last Name:	Iscandari
First Name:	Yvonne
Title:	Director, Division of Long Term Care
Agency:	Department of Health Care Finance
Address:	899 North Capitol Street, Sixth Floor
Address 2:	
City:	Washington
State:	**Dist. of Columbia**
Zip:	20002
Phone:	(202) 442-5899 **Ext:** ☐ **TTY**
Fax:	(202) 442-8114
E-mail:	yvonne.iscandari2@dc.gov

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

Last Name:	NA
First Name:	
Title:	
Agency:	
Address:	
Address 2:	
City:	
State:	**Dist. of Columbia**
Zip:	
Phone:	**Ext:** **TTY**
Fax:	
E-mail:	

8. Authorizing Signature

This document, together with 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:	Linda Elam
	State Medicaid Director or Designee
Submission Date:	Dec 5, 2011

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

Last Name:	Elam
First Name:	Linda
Title:	Deputy Director - Medicaid
Agency:	Department of Health Care Finance
Address:	899 North Capitol St. NE, Sixth Floor
Address 2:	
City:	

Washington

State: **Dist. of Columbia**

Zip: 20002

Phone: (202) 442-9075 **Ext:** **TTY**

Fax: (202) 442-8114

E-mail: linda.elam@dc.gov

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

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

Specify the transition plan for the waiver:

The renewal is a continuation of the existing waiver.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Continued from Appendix B, Quality Improvement Strategy:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

   (●) **The waiver is operated by the State Medicaid agency.**

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

   (●) **The Medical Assistance Unit.**

   Specify the unit name:
   The Department of Health Care Finance, Division of Long Term Care (DLTC)
   (Do not complete item A-2)

   ( ) **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

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

   (Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
DHCF utilizes a Quality Improvement Organization (QIO) for some waiver operational and administrative functions. The QIO functions for the waiver are:
*Review and determine Nursing Home Level of Care.
*Review EPD Waiver applications (new admissions, re-certifications, and change requests)
*Prior-authorizes EPD Waiver services

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

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

Appendix A: Waiver Administration and Operation

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

- (●) **Not applicable**
- ( ) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
  - [ ] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

    Specify the nature of these agencies and complete items A-5 and A-6:
  - [ ] **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
DHCF assigns a Contracting Officer Technical Representative (COTR) for all contracted entities working on behalf of the District. The COTR is responsible for oversight and the assessment of performance of the Contractor. The QIO is the contractor responsible for the identified portions of the waiver administration and contracted operations.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The method that is used to assess the performance of the QIO is a monthly Performance Review tool that includes myriad metrics including timeliness measures, denial rates, and appeal rates. The primary measure of note is a 95% timeliness rate for waiver prior authorization review within 5 business days. Performance is reviewed on a past-month basis.

Appendix A: Waiver Administration and Operation

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

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Percent of federally approved slots in the EPD waiver (denominator), filled with waiver enrollees (numerator).

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number of applicants to the EPD waiver (denominator) who reside on a waiting list (numerator) for EPD waiver services.

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports generated by the QIO

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

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

Performance Measure:
Percent of participants in the EPD waiver (denominator) who meet financial eligibility standards for participation in the EPD waiver (numerator).

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: FMS	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Sampling approach: Other: Convenience sample of 30 enrollees chosen at random using automated random selection program (i.e., RATSTAT or MMIS-adjunct software).	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Sampling approach: Other: Convenience sample of 30 enrollees chosen at random using automated random selection program (i.e., RATSTAT or MMIS-adjunct software).

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percent of paid claims for EPD waiver services (denominator) that were prior authorized (numerator).

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

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

Data Aggregation and Analysis:

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

While the state is responsible for the administration and operation of the entire waiver, two other entities apart from the State Medicaid agency perform key parts of the waiver enrollment and service authorization processes. These are: 1) the District of Columbia's (DC's) Department of Human Services' Economic Security Administration (ESA - formerly the Income Maintenance Administration – IMA) which conducts Medicaid eligibility determinations and financial eligibility determination for EPD waiver applicants who are not previously enrolled in Medicaid, and 2) a contractor that the state uses to perform Level of Care and prior authorization functions, including LOC and prior authorization of EPD waiver services for the EPD waiver program. Thus, the performance measures above will provide basic operational information on how effectively and reliably these two organizations will conduct activities related to enrollment in the waiver and prior

authorization of waiver services. As the above performance measures state. the state agency will review these two entities' performance no less frequently than quarterly. In addition to these performance measures, the state agency meets with the Contractor monthly and with ESA on a weekly basis. DHCF's Elders and Persons with Physical Disabilities Branch (EPPD) in the Division of Long Term Care is responsible for discovery and remediation activities related to waiver administration and oversight.

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

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

Responsible party: Manager, Division of Quality and Health Outcomes

Timeline: December 15, 2011

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

Responsible party: Manager, Division of Long Term Care

Timeline: January 1, 2012

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

Responsible party: Manager, Division of Long Term Care

Timeline: February 15, 2012

4. Production and submission of performance measures.

Responsible party: Manager, Division of Long Term Care

Timeline: March 1, 2012,

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Remediation and fixing individual problems are the responsibility of the State Agency's Division of Long Term Care (DLTC), Elders and Persons with Physical Disabilities Branch (EPPD) and its Manager EPPD has two approaches for remediation and problem solving. The first of the two approaches focuses on individual beneficiaries and aims to resolve each beneficiary's problems within 24 hours of its presentation. It is not a systematic quality improvement intervention, but an intervention to ensure that foremost a beneficiary is not harmed by the failure of the EPD program to operate in the way in which it is intended.

Such problems are handled by the six (as of 11/5/11) staff who work in EPPD. These staff have access to the states' eligibility and enrollment files, prior authorization records and case management datasbase. They can

identify the status of an application, status of a prior authorization request, identity of a case management agency, and these staff intervene quickly to ensure that no harm comes to a beneficiary. These staff document beneficiary complaints and requests for assistance in a tracking log book maintained by EPPD.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

○ **No**

◉ **Yes**

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

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

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

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

Manager, Division of Quality and Health Outcomes

December 30, 2011

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

Manager, Division of Quality and Health Outcomes

December 30, 2011

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

December 30, 2011

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

Manager, Division of Long Term Care

December 30, 2011

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

Manager, Division of Long Term Care

December 30, 2011

Appendix B: Participant Access and Eligibility

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

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

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

	☐				☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

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

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

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

○ **Not applicable. There is no maximum age limit**

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

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

○ **A level higher than 100% of the institutional average.**

Specify the percentage: ☐

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any

otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☐ **Additional services in excess of the individual cost limit may be authorized.**

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

- ☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	4660
Year 2	4760
Year 3	4860
Year 4	4960
Year 5	5060

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

- ○ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ◉ **The State limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	4050
Year 2	

	4162
Year 3	4278
Year 4	4397
Year 5	4520

Appendix B: Participant Access and Eligibility

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

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

- ○ **Not applicable. The state does not reserve capacity.**
- ◉ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
EPSDT (Early Periodic Screening Diagnostic Treatment)	
Money Follows the Person	

Appendix B: Participant Access and Eligibility

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

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

EPSDT (Early Periodic Screening Diagnostic Treatment)

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

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

(c) policies for the reallocation of unused capacity among local/regional non-state entities:
The District does not anticipate unused capacity for this target group because the demand is more than the available supply; however, the District is currently developing policies and procedures to include reallocation of any unused slots for the reserved capacity group to the target group with the most need at the start of the 12th month of the Waiver Year, in the event that there are any unused portions,

though very unlikely.

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

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

Appendix B: Participant Access and Eligibility

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

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

Money Follows the Person

Purpose *(describe):*

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

Although the EPD MFP transitions began later than anticipated in the District of Columbia, due to a variety of challenges and delays including meeting federal planning and data reporting requirements, community-level barriers such as lack of affordable and accessible housing and rental vouchers, local budgetary constraints, the District has begun utilization of the MFP program for this target population and today has transitioned a total of fifteen (15) individuals into the community from District of Columbia nursing homes during this calendar year and fifth year of the waiver and plans to continue with an increased number of forty (40) participants each waiver year to ensure a number of District residents who are currently in nursing homes can have a choice of where they live and receive services while the District provides less costly uncompromised care for them in their communities. Of the 15 who transitioned into the community, nine (9) of them currently participate in the EPD waiver while the other six (6) are receiving State Plan Personal Care Assistance and other community supports including substance abuse treatment, mental health supports-individual & group, HIV case management, and seniors' case management. There are currently eleven (11) transitions pending with discharges expected by December 31, 2011.

April 2010, District of Columbia Nursing Facility MDS data reported a total facility census of 2,516. those nursing facility residents, 2,080 were Medicaid beneficiaries.
2010 Quarter 2 MDS data (reported by The Delmarva Foundation in October 2011 as the latest accessible data) showed 62 nursing facility residents across the District's 19 nursing facilities who reported wanting to receive home and community-based services, having a positive support person in the community, and potential discharge in the next 90 days.
Based on the informal memo submitted to CMS, the District has revised its benchmark for the MFP EPD Waiver demonstration for 2011 through 2016 to have a benchmark of 40 transitions per calendar year. The District has, therefore, used this benchmark to determine the number of reserved slots for MFP participants for each of the waiver years beginning 2012 with the renewed waiver.

Capacity Reserved
CY/WY 2012: 40
CY/WY 2013: 40
CY/WY 2014: 40

CY/WY 2015: 40
CY/WY 2016: 40
Total MFP reservations: 200

Describe how the amount of reserved capacity was determined:

As approved in October 2010 by CMS in the MFP Operational Protocol dated 10.22.2010: Because of the limited number of MFP participant slots relative to the number of nursing facility residents who have expressed a desire to move, MFP will be implementing a lottery to select MFP participants from the pool of MFP-eligible individuals who have met screening requirements and submitted completed required documents (initial screen and consent) that initiate the MFP enrollment process.
The opportunity for participation in the lottery will be formally announced and actively encouraged for all residents in each of the District's nineteen nursing facilities.

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

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

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

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

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

Waiver Year	Capacity Reserved
Year 1	40
Year 2	40

Year 3	40
Year 4	40
Year 5	40

Appendix B: Participant Access and Eligibility

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

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

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Eligibility criteria consist of the following: 1) Medicaid eligibility with a maximum monthly income of three hundred percent (300%) of Supplemental Security Income (SSI); 2) The beneficiary requires the care furnished in a nursing facility under Medicaid verified by an approved nursing home level of care; 3) The beneficiary is 65 and older, or an adult 18 and over with physical disabilities; and; 4) The beneficiary is not an inpatient of a hospital, nursing facility or intermediate care facility for the mentally retarded.

As indicated in eligibility, there are reserved capacities set aside for the EPD waiver in the following amounts: 40 beneficiaries for MFP and 15 beneficiaries for EPSDT enrollees who age out of the program or are eligible to enroll in the EPD waiver. Once the reserved capacities are established, there are no additional preferences and waiver participation is allocated on a first-come, first-served basis.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (•) **No**
   - ( ) **Yes**

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

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

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional State supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - (•) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

  Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

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

- ( ) **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- (•) **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

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

Check each that applies:

- ☑ **A special income level equal to:**

  Select one:

  - ◉ **300% of the SSI Federal Benefit Rate (FBR)**
  - ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

    Specify percentage:
  - ○ **A dollar amount which is lower than 300%.**

    Specify dollar amount:
- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- ☑ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- ☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- ☑ **Aged and disabled individuals who have income at:**

  Select one:

  - ◉ **100% of FPL**
  - ○ **% of FPL, which is lower than 100%.**

    Specify percentage amount:
- ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

◉ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

◉ **The following standard included under the State plan**

Select one:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

◉ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the State Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable (see instructions)

SSI standard

Optional State supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

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

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

State does not establish reasonable limits.

The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

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

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- (●) **By an entity under contract with the Medicaid agency.**

Specify the entity:

Performance of Medicaid Level of Care is conducted annually by the State Quality Improvement Organization (QIO).

- ( ) **Other**

Specify:

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

The initial Level of Care is performed by
• A Physician (MD or D.D)
• Registered Nurse, Licensed in the State
• Licensed Social Worker
• Case Manager pursuant to case management standards Chapter 42 of Title 29 of the District of Columbia Municipal Regulations.

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.

To satisfy the LOC requirement, beneficiaries must meet criteria that address functional limitations in activities of daily living and instrumental activities of daily living. Extensive assistance or total dependence with at least two (2) of the following five (5) basic activities: bathing, dressing, mobility, eating, and toilet use OR
Supervision or limited assistance with at least 2 of the following five basic activities: bathing, dressing, mobility, eating, and toilet use AND extensive assistance, total dependence, supervision, or limited assistance in at least three (3) of the following five (5) instrumental activities: medication management, meal preparation, housekeeping, money

management, and telephone use.

Individuals are informed of any feasible alternative under the waiver and given the choice of either institution or home and community-based services.

Specifically, individuals must require:

1. Extensive assistance or total dependence with at least 2 of the following 5 basic activities of daily living (ADLs): bathing, dressing, mobility, eating, and toilet use OR

2. Supervision or limited assistance with at least 2 of the following 5 basic activities of daily living (ADLs): bathing, dressing, mobility, eating, and toilet use AND extensive assistance, total dependence, supervision, or limited assistance in at least 3 of the following 5 instrumental activities of daily living (IADLs): medication management, meal preparation, housekeeping, money management, and telephone use.

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 but cannot perform without help from staff or cannot do for self at all

DHCF instrument/tool used to capture this information is the Form 1728 – Request for Medicaid Nursing Facility Level of Care. Form 1728 and DHCF's State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool will be made available to CMS upon request through DHCF.

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

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

Case managers are responsible for conducting a comprehensive assessment and annual reevaluation of the beneficiary's functional, social, and behavioral needs and submit a request to the QIO to make a LOC determination. Case managers conduct assessment utilizing the Individualized Service Plan, Client Health History and an EPD 2010-1 Guidelines Worksheet for Determining Personal Care Aide Service Hours Under the EPD Waiver Program.

Approvals for the Level of Care are performed by the QIO.

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

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform

reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  Specify the qualifications:

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

Case managers are responsible for ensuring that annual and as needed Level of Care (LOC) re-evaluations are conducted and reported to State agency.
• Annual recertifications of an LOC must be submitted at least 90 days prior to the expatriation of the current prior-authorized for services.
• As needed LOC, and/or reassessments, are contingent on change in beneficiaries' level of functioning based on hospitalization or stay in a rehabilitation facility.
• The electronic case management system Casenet also sends a Task “message” to the case manager to inform that the beneficiary is due for recertification.

The financial technical eligibility for reevaluations are processed the same way as for the initial application at ESA (formerly IMA). A system-generated written approval notice is sent to the beneficiary informing him/her about his/her period of eligibility.

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
Number and percent of all new enrollees who have a level of care indicating need of nursing home care prior tothe receipt of waiver services. N: # of new enrollees who have a level of care indicating need of nursing home care before receiving waiver services D: # of new enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Casenet

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: QIO	☐ **Annually**

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports generated by QIO

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: QIO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports generated by QIO

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Contractor performing LOC determinations.	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIO System and Casenet

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Sampling approach: Convenience sample of 30 enrollees chosen at random using automated random selection program (i.e., RATSTAT or MMIS-adjunct software).
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Casenet

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%, 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Semi-Annualy	

Data Aggregation and Analysis:

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

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

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

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

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

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

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

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

Although this full strategy will not be in place until January 2012, below are the task that will be undertaken in the next three months to fully develop and implement DHCF's strategy for Continuous Quality Improvement of service delivery via this waiver. Task completion will be directed by DHCF's Director of HCDMA and Manager of the Division of Quality and Health Outcomes, who together have substantial experience and expertise in health care quality measurement and improvement in general, and for the Medicaid program, in

particular.

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Remediation and fixing individual problems are the responsibility of the State Agency's Division of Long Term Care (DLTC), Elders and Persons with Physical Disabilities Branch (EPPD) and its Manager. EPPD has two approaches for remediation and problem solving. The first of the two approaches focuses on individual beneficiaries and aims to resolve each beneficiary's problems within 24 hours of its presentation. It is not a systematic quality improvement intervention, but an intervention to ensure that foremost a beneficiary is not harmed by the failure of the EPD program to operate in the way in which it is intended.

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

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

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

○ **No**

◉ **Yes**

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

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

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

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

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

Responsible party: Manager, Division of Long Term Care

Timeline: January 1, 2012

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

Responsible party: Manager, Division of Quality and Health Outcomes

Timeline: January 1, 2012

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

Responsible party: Manager, Division of Long Term Care

Timeline: February 1, 2012,

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

Responsible party: Manager, Division of Long Term Care

Timeline: February 1, 2012,

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful

access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
• The contractual agencies are responsible for obtaining interpretation services
• 4204.1 – Each provider of Waiver services shall establish a plan to adequately provide services to non English speaking participants. The provider shall identify the necessary resources and individuals in order to implement the plan. Identification of necessary resources may include referring the recipient to another services provider agency or businesses with staff that is able to meet the particular language need of the recipient.
• DHCF also has an established language interpreter service

Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Case Management
Statutory Service	Homemaker
Statutory Service	Personal Care Aide
Statutory Service	Respite
Other Service	Assisted Living
Other Service	Chore Aide
Other Service	Environment Accessibility and Adaptation Services
Other Service	Participant Directed Goods and Services
Other Service	Participant-Directed Personal Care Services
Other Service	Personal Emergency Response System (PERS)

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

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

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):*
Scope:
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.
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.
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:

• Activities associates with the customer to access waiver services. These activities include obtainment of a level of care determination and financial eligibility documentation
• Completion of the comprehensive customer assessment,
• Development of the comprehensive ISP utilizing interdisciplinary team members, customers 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; implementation of services.
• Assisting the participants select service providers
• Assisting participants with securing necessary physician orders when required for the initiation of and service providers
• Assisting participants 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 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.
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).

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Case Management Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Home Health Agencies are required to be licensed in the District of Columbia. Staff providing Case Management must have current appropriate licensure, and have a Masters and one year of experience with the population, with either a degree in Social work, Psychology, Counseling, Rehabilitation, Nursing, Gerontology, or sociology OR a Bachelors degree and the above current licensure and 2

years of experience with the population OR Registered Nurse [RN] can have an Associate Degree and 3 years of experience.

Health Regulation Licensing Administration requirements are documented in the DCMR Home Care Agencies, Title 22, Chapter 39.

Waiver rules, “Home and Community-Based Waiver Services for Persons who are Elderly and Individuals with Physical Disabilities,” are documented in the DC Municipal Regulations (DCMR) Title 29, Chapter 42, and specify the following:
Bachelors degree and the above current licensure and 2 years of experience with the population.

Registered Nurse can [RN] can have an Associate Degree and 3 years of experience, and current license

Health Regulation Administration requires: DCMR Home Care Agencies Title 22, Chapter 39.” 3900.5

Certificate *(specify):*

Other Standard *(specify):*
Social Service Agency and Community-Based Organization: By-laws or similar documents regulating conduct of providers internal affairs
Policies and procedure and QA Plan

Minimum standards-
• 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 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 Medicaid 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.

• 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 (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.

The case manager from the case management service provider leads the development of the ISP by including the participant and/or legal representative, family members, friends of the participant, and any other appropriate individual in the process.
The qualifications for a case manager are specified in Chapter 42 of Title 29, 4216.2 (a-c) 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," and read as follows:

" An individual conducting case management services shall meet one of the following requirements:
1. Have a current appropriate licensure, and have a Masters degree in social work, psychology, counseling, rehabilitation, nursing, gerontology, or sociology and have at least one (1) year of experience working with the elderly or individuals with physical disabilities;
2. Have a current appropriate licensure and have a Bachelors degree in social work, psychology, counseling, rehabilitation, nursing, gerontology, or sociology and have two (2) years of experience working with the elderly or individuals with physical disabilities; or
3. Have a current licensure as a Registered Nurse (RN), and have an Associate degree in nursing and at least three (3) years of experience working with elderly and individuals with physical disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCF Division of Long Term Care and DHCF Office of Program Operations
Frequency of Verification:
DHCF Division of Long Term Care: At least every 12 months during monitoring site visit

DHCF Office of Program Operations: At least 18 - 24 months

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Case Management Agency
Provider Qualifications

License *(specify):*
Community-Based Organization: Staff providing Case Management must have current appropriate licensure, and have a Masters and one year of experience with the population, with either a degree in Social work, Psychology, Counseling, Rehabilitation, Nursing, Gerontology, or sociology OR a Bachelors degree and the above current licensure and 2 years of experience with the population OR Registered Nurse [RN] can have an Associate Degree and 3 years of experience.

Health Regulation Licensing Administration requirements are documented in the DCMR Home Care Agencies, Title 22, Chapter 39.

Waiver rules, "Home and Community-Based Waiver Services for Persons who are Elderly and Individuals with Physical Disabilities," are documented in the DC Municipal Regulations (DCMR) Title 29, Chapter 42, and specify the following:
Bachelors degree and the above current licensure and 2 years of experience with the population.

Registered Nurse can [RN] can have an Associate Degree and 3 years of experience, And current license

Health Regulation Administration requires: DCMR Home Care Agencies Title 22, Chapter 39." 3900.5

Certificate *(specify):*

Other Standard *(specify):*
Social Service Agency and Community-Based Organization: By-laws or similar documents regulating conduct of providers internal affairs
Policies and procedure and QA Plan

Minimum standards-
• 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 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 Medicaid 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.

• 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 (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.

The case manager from the case management service provider leads the development of the ISP by including the participant and/or legal representative, family members, friends of the participant, and any other appropriate individual in the process.
The qualifications for a case manager are specified in Chapter 42 of Title 29, 4216.2 (a-c) 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," and read as follows:

" An individual conducting case management services shall meet one of the following requirements:
1. Have a current appropriate licensure, and have a Masters degree in social work, psychology, counseling, rehabilitation, nursing, gerontology, or sociology and have at least one (1) year of experience working with the elderly or individuals with physical disabilities;
2. Have a current appropriate licensure and have a Bachelors degree in social work, psychology, counseling, rehabilitation, nursing, gerontology, or sociology and have two (2) years of experience working with the elderly or individuals with physical disabilities; or

3. Have a current licensure as a Registered Nurse (RN), and have an Associate degree in nursing and at least three (3) years of experience working with elderly and individuals with physical disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCF Division of Long Term Care and DHCF Office of Program Operations

Frequency of Verification:
DHCF Division of Long Term Care: At least every 12 months during monitoring site visit

DHCF Office of Program Operations: At least 18 - 24 months

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

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

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.

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

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Homemaker; There are no agency providers.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Individual

Provider Type:
Homemaker; There are no agency providers.

Provider Qualifications

License *(specify):*
Valid Business License in good standing

Certificate *(specify):*
NA

Other Standard *(specify):*
All persons who apply for certification from the Vendor F/EA FMS Supports-Broker Entity to provide these services must be at least 18 years of age. All persons must be able to demonstrate to the EPD waiver participant the ability to successfully communicate with them. Individuals and businesses providing services and supports shall have all the necessary licenses required by federal, state and local laws and regulations, IF APPLICABLE.

Verification of Provider Qualifications

Entity Responsible for Verification:
The contracted Vendor F/EA FMS/Supports Brokerage entity selected by the RFP process will approve the individual or vendor through which the participant purchases individual-directed goods and/or services.

Frequency of Verification:
At initial certification to verify approval and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):
Personal Care Aide

HCBS Taxonomy:

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

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 that are provided when personal care services furnished under the approved State plan limits are exhausted. The scope and nature of these services do not differ from personal care services furnished under the State plan. The provider qualifications specified in the State plan apply.
Allowable Tasks: Personal Care Aide (PCA) services include the following tasks: bathing, grooming, assistance with toileting, or bed pan use; changing urinary drainage bags; assisting recipients with self-administered medications (aide may remind bur cannot administer the medication to the recipient); reading and recording temperature, pulse, and respiration; observing and documenting the recipient's status and verbally reporting to the RN or the case manager the findings immediately for emergency situations and within four hours for other situations; meal preparation in accordance with dietary guidelines and assistance with eating and feeding; tasks related to keeping the recipient's living areas in a condition that promotes the recipient's health, comfort, and safety; accompanying the recipient to medically-related appointments or place of employment; providing assistance at the recipient's place of employment; shopping for items to promote the recipient's nutritional status and other health needs; recording and reporting to the supervisory health professional and case manager any changes in the recipient's physical condition, behavior, or appearance; infection control; and accompanying the recipient to approved recreational activities.
Tasks include assistance with activities of daily living and instrumental activities of daily living. Services involving assistance with one or more activities of daily living that is rendered by a qualified personal care aide under the supervision of a registered nurse. 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.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
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 limitations are provided in accordance with an approved ISP and are cost effective.
A participant may receive up to 16 hours/7days a week of personal care aide services.
• 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.

Limitations on services PCAs can provide are:
1. PCA services shall not include services that require the skills of a licensed professional, such as catheter insertion, procedures requiring the use of sterile techniques, and medication administration.
2. Shall not include tasks usually performed by chore workers, such as cleaning of areas not occupied by the recipient, laundry for family members, and shopping for items not used by the recipient.
3. Shall not be provided in a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease.
4. When a recipient is receiving PCA services and homemaker services from two different staff persons who are employees of the same agency, all supervisory registered nurse (RN) visits shall be coordinated so that supervisory in-home RN visits are made in accordance with waiver standards and the supervisory in-home RN visits are made by the same supervising RN at the same time.

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

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

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

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care Aide

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications

License *(specify):*
Agencies must be licensed as a Home Health Agency by Health Regulation and Licensing Administration to do business in the District of Columbia.
Certificate *(specify):*

Other Standard *(specify):*
Agencies must be in compliance with the District of Columbia, Department of Health, Health Regulation and Licensing 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

All persons performing PCA services must complete a 75-hour initial training course and hold a Home Health Aide or Certified Nurse Assistant (CNA) 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.

Providers must also be in compliance with the 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 Division 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 Division checks the application for Professional Licensure and 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, Division of Long Term Care for review of the following:

• 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
• 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 requirement are Quality Improvement Plan, Admission process, Code of conduct, Policies and procedures, agency complaint process.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCF

Frequency of Verification:

DHCF Division of Long Term Care: At least every 12 months during monitoring site visit

DHCF Office of Program Operations: At least 18 - 24 months

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

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 provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Federal financial participation is not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite services may cover the range of activities associated with the Personal Care Aide role or the Homemaker role. These include:

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

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

Respite services shall not include services that require the skills of a licensed professional, including catheter insertion, procedures requiring sterile techniques, and medication administration.

Respite services shall not include tasks usually performed by chore workers, including cleaning of areas not occupied by the recipient, cleaning laundry for family members of the recipient, and shopping for items not used by the recipient.

Respite services shall not be provided to recipients who have no primary caregiver that is responsible for the

provision of the recipient's care on an ongoing basis.

Respite services are limited to a maximum of four hundred and eighty (480) hours per year. Requirements for respite services in excess of the established limits must be approved by DHCF prior to the provision of the services.

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

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

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

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Home Health Agency

Provider Qualifications

License *(specify):*
Agencies must be licensed to do business in the District of Columbia pursuant to the Department Of Health's Regulations. The D.C. DOH Health Regulation Administration requires in their municipal regulations (D.C.M.R) that all Home Care Agencies be licensed pursuant to Title 22, Chapter 39 3900.5. Additionally, these license requirements are also delineated in the EPD regulations (see Title 29, Chapter 42, section 4227.1).

Certificate *(specify):*
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 aide.
Staff providing respite care must complete twelve hours [12] of continuing education annually

Other Standard *(specify):*
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

-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.
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
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.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCF Division of Long Term Care verifies credentials of the provider agency and staff initially and proportionate sampling of the staff credentials annually

DHCF Office on Program Operations verifies all Home Health Agency licensure

Frequency of Verification:
DHCF Divison of Long Term Care verifies the qualifications during the provider application initial review to become a provider and every 12 months during site visits

DHCF Office of Program Operations verifies qualifications during the provider application initial review to become a provider and at 18-24 months.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Assisted Living

HCBS Taxonomy:

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

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):*
Assisted living services are personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to waiver participants who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). Services that are provided by third parties must be coordinated with the assisted living provider.
All activities associated with providing or coordinating personalized assistance through activities of daily living, recreational activities, 24-hour supervision, and provision or coordination of health services and instrumental activities of daily living.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Assisted living services 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.

Assisted Living service does not include housing or meals. Payment will not be made for 24 hour skilled care or supervision; room and board; costs of facility maintenance; and upkeep and improvement.

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

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

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

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living Facility

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living

Provider Category:
Agency
Provider Type:
Assisted Living Facility
Provider Qualifications
License *(specify):*
Facility must be licensed by the District of Columbia Health Regulation Administration

Staff RN and/or LPN must maintain current State license
Certificate *(specify):*
Copies of current license and certification of staff, Personal Care Aides. Medication Technician, Homemaker
Other Standard *(specify):*
In compliance with Assisted Living Resident Regulatory Act of 2000

In compliance with 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

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCF Division of Long Term Care

DHCF Office of Program Operations

District of Columbia, Dept. of Health, Health Regulation Licensing Administration

Frequency of Verification:
DHCF Division of Long Term Care reviews and verifies qualifications during the provider application initial review to become a provider and every 12 months during site visits

DHCF Office of Program Operations reviews and verifies qualifications during the provider application initial review to become a provider and at 18-24 months.

District of Columbia, Dept. of Health, Health Regulation Licensing Administration verifies upon review and approval of initial license and every three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Chore Aide

HCBS Taxonomy:

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

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):*
Chore Aide services consist of heavy, one unit (typically one day but can be up to four days at a time) of non medical, household remediation tasks intended to place the home environment in a clean, sanitary and safe condition. Ideally, the chore aide prepares the home environment so as to be safe and clean that make the way for more routine and ongoing routine homemaker services. This includes heavy house cleaning of the household so as to initially ensure the homemaker and/or Personal Care Aide can conduct light household cleaning on a more routine basis.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A unit is a one hour unit spent performing allowable task(s). Maximum amount of service permitted under the waiver is 32 units (quantity of four, eight-hour days) and is strictly a one-time service for recipients in the EPD waiver. 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.
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.

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

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

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

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Aide

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
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
Certificate *(specify):*
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.
Other Standard *(specify):*
Agencies must have bylaws or similar documents regulating conduct internal affairs Policies and Procedures
• 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]
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.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCF Division of Long Term Care verify credentials of staff initially and ten percent sampling of the staff credentials annually.

DHCF Office on Program Operations verify all Home Health Care Agency licensure
Frequency of Verification:
Qualifications are verified by DHCF/DLTC during the provider application initial review to become a provider and every 12 months during monthly site visits

Qualifications are verified by DHCF Program Operations during the provider application initial review to become a provider and at 18-24 months.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Environment Accessibility and Adaptation Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

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

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 private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The maximum allowable cost per 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.
EAA services will be approved or reimbursed only for a customer who can demonstrate that they have attempted to qualify for the Handicap Accessibility Improvement Program (HAIP) administered by the DC Department of Housing and Community Development and 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 or 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.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title

Individual	Construction contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environment Accessibility and Adaptation Services

Provider Category:
Individual

Provider Type:
Construction contractor

Provider Qualifications

License *(specify):*
Valid Business License in good standing

Certificate *(specify):*
NA

Other Standard *(specify):*
All persons who apply for certification from the Vendor F/EA FMS Supports-Broker Entity to provide these services must be at least 18 years of age. All persons must be able to demonstrate to the EPD waiver participant the ability to successfully communicate with them. Individuals and businesses providing services and supports shall have all the necessary licenses required by federal, state and local laws and regulations, IF APPLICABLE.

Verification of Provider Qualifications

Entity Responsible for Verification:
DCRA

Frequency of Verification:
At initial certification to verify approval and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Participant Directed Goods and Services

HCBS Taxonomy:

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

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

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):*
Participant Directed Goods and Services, are services and equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the participant's safety in the home environment; AND, the participant does not have the funds to purchase the item or service or the item or service is not available through another source. Participant Directed Goods and Services are purchased from the participant-directed budget. Experimental or prohibited treatments are excluded. Participant Directed Goods and Services must be documented in the service plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
EPD waiver participants who select to participant-direct may purchase individual-directed goods and services that are included in their ISP, meet the criteria listed above and are within the means of their participant-directed individual budget to purchase. Supports brokers will help beneficiaries amend their ISPs as necessary to account for new, appropriate goods and services that beneficiaries would like to purchase and help them manage their individual budgets. DLTC will conduct regular review of ISPs to ensure that goods and services purchased are appropriate and within the budget constraints.

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

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

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

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Individual as selected by the participant; Retail vendors for food items, household supplies, etc

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant Directed Goods and Services

Provider Category:
Agency
Provider Type:
Individual as selected by the participant; Retail vendors for food items, household supplies, etc.
Provider Qualifications
License *(specify):*
Valid Business License in good standing
Certificate *(specify):*

NA

Other Standard *(specify):*

All persons who apply for certification from the Vendor F/EA FMS Supports-Broker Entity to provide these services must be at least 18 years of age. All persons must be able to demonstrate to the EPD waiver participant the ability to successfully communicate with them. Individuals and businesses providing services and supports shall have all the necessary licenses required by federal, state and local laws and regulations, IF APPLICABLE.

Verification of Provider Qualifications

Entity Responsible for Verification:

The contracted Vendor F/EA FMS/Supports Brokerage entity selected by the RFP process will approve the individual or vendor through which the participant purchases individual-directed goods and/or services.

Frequency of Verification:

At initial certification to verify approval and thereafter as needed.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Participant-Directed Personal Care Services

HCBS Taxonomy:

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

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):*

Participant-Directed Personal Care Services consist of assistance with personal care, of both a supportive and health-related nature, specific to the self-directed needs of persons with a physical disability or elders.

Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. Housekeeping, chore, and respite activities, and escorts to medical appointments may also be furnished as part of this activity. Participants manage their participant's individual budget and recruit, dismiss, manage and dismiss their own staff. They may appoint someone to act as their representative if they do not wish to personally direct their own care.

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

The Participant-Directed Personal Care Services are no different from the scope of services offered to waiver recipients who do not choose to participate in Participant-Directed services. Therefore, 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 limitations are provided in accordance with an approved ISP and are cost effective.

A participant may receive up to 16 hours/7days a week of personal care aide services.

• 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.

Limitations on services PCAs can provide are:

1. PCA services shall not include services that require the skills of a licensed professional, such as catheter insertion, procedures requiring the use of sterile techniques, and medication administration.
2. Shall not include tasks usually performed by chore workers, such as cleaning of areas not occupied by the recipient, laundry for family members, and shopping for items not used by the recipient.
3. Shall not be provided in a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease.
4. When a recipient is receiving PCA services and homemaker services from two different staff persons who are employees of the same agency, all supervisory registered nurse (RN) visits shall be coordinated so that supervisory in-home RN visits are made in accordance with waiver standards and the supervisory in-home RN visits are made by the same supervising RN at the same time.

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

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

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

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual, Independent; Agency as an alternate

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant-Directed Personal Care Services

Provider Category:
Individual

Provider Type:
Individual, Independent; Agency as an alternate

Provider Qualifications

License *(specify):*
Individual, Independent

Agency as an alternate

Certificate *(specify):*
NA

Other Standard *(specify):*
Qualified direct care workers, the personal care service providers, are private individuals recruited, hired, supervised, managed and dismissed by the participant. Qualified direct care workers can only be paid at the maximum allowable rate for a personal care provider. Qualified direct care workers must have demonstrated the skills necessary to meet the customer's needs. The supports broker is responsible for verifying that the provider has the training, education and experience required to perform the tasks. Training requirements are specified in the service description below.

All persons performing personal care services must:
a. Be 18 years of age or older;
b. 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. Code, d32-1351 et seq.);
c. Sign a home and community-based service provider contract or agreement with the Department (delegated to the Vendor F/EAFMS/Supports Brokerage entity) to provide services to waiver recipients;
d. Complete minimum training requirements prior to service, and any additional training requirements outlined in the Individual Service Plan (ISP) within 30 days of beginning service;
e. Be free of any communicable diseases; and
f. Be, in the supports broker's judgment, able to foster a healthy, working relationship with the waiver recipient.

Training Requirements:

1. All persons performing personal care services must meet training plan requirements specific to the individual customer as specified in the ISP.

2. The qualified direct care worker must receive a certificate from the Medicaid office or its delegate (Vendor F/EA FMS/Supports Brokerage entity) indicating that the minimum training plan as described in the participant's ISP was successfully completed before services are provided to a Medicaid recipient, and any additional requirements were completed within 30 days of service state date.

3. The training plan must include:
• Minimum Requirements:
o CPR
o First aid/vital signs/emergency
o Information about how to ensure participant's rights, autonomy and community inclusion
o DHCF, DDS and/or Vendor F/E A administrative procedures and requirements
• Additional requirements as described in the ISP
o ADLs/IADLs training based on participant's ISP

4. The waiver participant may provide training to the personal care provider in the health-related tasks that the customer self-directs in addition to training required by OCLTC and the Vendor F/EAFMS/Supports Brokerage entity.

5. Qualified direct care workers may be exempt from portions of the health and patient care-related training requirements such as CPR and first aid if he/she can:
a. Provide documentation and/or license or certification that they have received training in CPR and/or first aid emergency care and/or specific skills required of an direct care worker by the participant;
b. If they area:
(1) ;
(2) Personal care worker;
(3) Certified nursing assistant; or
(4) Home health aide; or
(5) Personal care provider
The Vendor F/EA FMS-Supports Broker entity will determine if a qualified direct care worker may be exempt from training requirements, and OCLTC will approve or disapprove the exemption based on documentation of the f the above examples for exemptions that must be maintained within the

waiver participant's case file.
c. Applicability of the services is consistent with the rules of the Personal Care Aide and has been added to the service rules.

6. Where an EPD waiver participant is willing and in the supports broker's judgment capable of providing any parts of the required training, the supports broker should empower the customer to do so. However, all of the following must be adhered to when the participant is designated to conduct components or the provider training:
a. Any such decision shall be agreed upon by the participant and documented in the ISP
b. There must be a list of areas of training provided by the customer, signed by the customer and kept in the file of the case manager or provider agency;
c. Of the required training components, the ISP must clearly identify how each is to be addressed by the participant, and/or by another trainer.

Additional requirements:

The qualified direct care worker must:
1. Understand the individualized service plan (ISP);
2. Contact the participant's representative and supports broker when there are changes which affect the care outlined in the ISP
3. Observe the participant for change(s) in health, take appropriate action, and respond to health-related emergencies;
4. Notify the supports broker/ case managers immediately when the customer enters a hospital, or moves to another setting;
5. Notify the supports broker immediately if the participant dies;
6. Notify the designated participant and/or representative if applicable at least twenty four hours ahead of scheduled time when unable to serve the participant; and
7. Notify DHCF and designated employer when the provider will no longer provide services. Notification to the customer/ legal guardian must:
a. Give at least two weeks notice, and
b. Be in writing.

8. In addition to the above requirements, the qualified direct care worker must

a. Complete and keep accurate timesheets that are accessible to the supports broker or individual providing supervision.
b. Maintain certain employment standards, which include:
1. Maintaining a drug and alcohol free work place;
2. Absence of criminal activity;
3. Skills, knowledge, ability, and willingness to provide services.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS

Frequency of Verification:
Upon initial certification and therafter annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

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

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):*
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.
• 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:
One to twenty-four hours spent performing allowable tasks. Each waiver customer may receive a maximum of :
• 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 emergency calls. Respondents may be relatives, friends, neighbors or medical personnel.

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

- ☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	EPD provider type in MMIS, coded as W02.

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
EPD provider type in MMIS, coded as W02.

Provider Qualifications

License *(specify):*
Business in good standing

Certificate *(specify):*
NA

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCF

Frequency of Verification:
Annually and more frequently, on an as needed basis.

Appendix C: Participant Services

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

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

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

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

Check each that applies:

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

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

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

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

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

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

Appendix C: Participant Services

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

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

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

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

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

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

- ◉ **No. The State does not conduct abuse registry screening.**
- ○ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

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

Appendix C: Participant Services

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

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

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

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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

Facility Type	
Assisted Living	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Individuals in Assisted Living units are expected to maintain a high level of independence within and outside of the facility, with supports built into activities of daily living. Individuals who live in such independent settings have the choice of flourishing in a self-governing, semi-structured enriched environment. These facilities provide for privacy and easy access to visitors at times convenient to the individual, and provide resources and activities in the community.

Individuals are expected to remain largely autonomous and typically as expected will require assistance in the morning with bathing and dressing, and as needed in the evenings but are expected to ambulate independently or use assistive devices outside of the residential facility and within the larger community on a daily basis. Personalized care is designed to assist individuals to remain independent. Each assisted living unit offers individuals a variety of independent amenities such as apartment style living with kitchenette, bedroom, bathroom and living room whereby individuals can choose to cook their own meals and reside in an independent environment with some help, as needed.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Chore Aide	☐
Participant-Directed Personal Care Services	☐
Participant Directed Goods and Services	☐
Case Management	☑
Personal Care Aide	☑
Homemaker	☐
Environment Accessibility and Adaptation Services	☐
Assisted Living	☐
Personal Emergency Response System (PERS)	☐
Respite	☑

Facility Capacity Limit:

The size of each facility shall be governed by the Assisted Living regulations and shall not serve more than 50 participants, as designated/approved by the Licensing division.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☐
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

The Assisted Living Residence Regulatory Act of 2000 does not speak specifically to ratios but states that a residence Employ staff and develop a staffing plan in accordance with the act and based upon the following criteria:
(A) The health, mental condition, and psychosocial needs of the residents;
(B) The fulfillment of the 24-hours-a-day scheduled and unscheduled needs of the residents;
(C) The size and layout of the ALR;
(D) The capabilities and training of the employees; and
(E) Compliance with all of the minimum standards in this act; to assure the safety and proper care of residents in the Assisted Living Residence.

EXPLANATION OF HOW HEALTH AND WELFARE OF PARTICIPANTS IS ASSURED IN THE STANDARD FOR INCIDENT REPORTING
The District uses a variety of mechanisms to monitor the health and welfare of waiver participants, including a complaint database and a DLTC Monitoring Unit that serves as a point of contact for identifying complaints and incidents and initiating appropriate actions in response to such complaints and incidents. Specifically, when an incident is reported to the DLTC Monitoring Unit by a provider, beneficiary or another entity, the unit contacts the beneficiary's provider and initiates one of the following activities: refers the incident to the Adult Protective Services (APS), refers the incident to another appropriate agency or begins a corrective action immediately. The process to address the complaint begins with a combination of the following: an announced or unannounced visit to the provider agency and/or beneficiary's home or a conference call between all parties to discuss the complaint. Also, the DLTC Monitoring Unit will review clinical records, personnel files, complaint/incident binders, etc. to obtain additional, relevant information. DLTC staff will recommend that the provider, in conjunction with the beneficiary, develop or revise a plan to prevent similar incidents from occurring in the future. Also, providers must file an electronic incident report within 24 hours of incident occurrence through the District's electronic case management system, Casenet. Such

reports are reviewed by the DLTC Monitoring Unit and the above-referenced actions are initiated.

With regard to critical events or incidents, there is a requirement that each EPD Waiver provider must submit through Casenet and/or via fax any unusual incident report within 24 hours. This includes falls that result in hospitalization, perceived abuse or neglect or major injury to a client. This information is placed in an unusual incidents log at DHCF that includes the specifics of the accident or unusual incident. DLTC staff contacts the provider and request specific details of the event including mitigation response/s and future adjustments to the plan of care, as warranted. DHCF staff monitors the provider and client for health and safety concerns. If the provider was at fault and made no corrective actions, the client is moved to another provider and provider may receive sanctions, including DHCF and Health Regulation Licensing Administration (HRLA) visits, no new referrals to the provider until all necessary corrective actions are taken. In the event of egregious actions, the cases are referred to the DHCF Office of Program Integrity, Medicaid Fraud and Control Unit of the Inspector General, as needed. If the incident or event is properly addressed DHCF notes in log follow-up response or follow-up during next provider visit. Data collected from the provider is also gathered on a quarterly basis, and reported on in the Continuous Quality Improvement Report, and shared with CMS in the District's EPD Waiver quarterly report.

With respect to corrective action planning (CAP), the EPD Monitoring team's goal is to ensure the provider agency is in compliance with its provided CAP. The EPD Monitoring team will make an unannounced visit to follow-up with the provider within a 60 calendar day time frame, to ensure remediation activities are concurrent with the CAP plan submitted by the provider. If the subsequent EPD Monitoring Team demonstrates the provider is not implementing its CAP according to the submitted specifications, the provider must supply another CAP within 15 calendar days and DHCF will impose sanctions. The sanctions policy is in development and ranges from the suspension of new referrals to the provider, to a letter with the intent to terminate the provider from DC Medicaid enrollment.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ○ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ◉ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

(a) The District does make payments to legally responsible individuals for furnishing care or similar services for individuals who do not self-direct. These family members can receive compensation for PCA services under very strict guidelines. According to the rules, a waiver recipient may choose an individual or a family member other than a spouse, or parent of a minor recipient, or other legally responsible relative to provide PCA services, who shall meet the following requirements:
1. Be at least 18 years of age.

2. Be a citizen of the US or lawfully authorized to work in the US.
3. Complete a home health aide training program which includes at least 75 hours of classroom training, with at least 16 hours devoted to supervised practical training, and pass a competency evaluation for those services which the PCA is required to perform, consistent with the requirements set forth in 42 CFR 484.36, and provide a copy of the certificate and competency evaluations.
4. Be certified in cardiopulmonary rescuscitation (CPR) and obtain CPR certification annually.
5. Be able to read and write the English language at a 5th grade level and carry out instructions and directions.
6. Be able to recognize an emergency and be knowledgeable about emergency procedures.
7. Be knowledgeable about infection control procedures.
8. Be acceptable to the recipient and not be a spouse, parent of a minor recipient, or other legally responsible relative.
9. Demonstrate annually following the Centers for Disease Control guidelines that s/he is free from communicable disease, as confirmed by a chest x-ray or by an annual Purified Protein Derivative (PPD) Skin Test or documentation from a physician stating that the person is free from communicable disease.
10. Pass a criminal background check pursuant to the Health Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999, DC Law 12-238.
11. Provide documentation of acceptance or declination of the Hepatitis vaccine.
12. Be supervised by a registered nurse.

Payment may be made for the following personal care or similar services as follows: basic personal care, including bathing, grooming, assistance with toileting, or bed pan use; changing urinary drainage bags; assisting recipients with self-administered medications (aide may remind bur cannot administer the medication to the recipient); reading and recording temperature, pulse, and respiration; observing and documenting the recipient's status and verbally reporting to the RN or the case manager the findings immediately for emergency situations and within four hours for other situations; meal preparation in accordance with dietary guidelines and assistance with eating and feeding; tasks related to keeping the recipient's living areas in a condition that promotes the recipient's health, comfort, and safety; accompanying the recipient to medically-related appointments or place of employment; providing assistance at the recipient's place of employment; shopping for items to promote the recipient's nutritional status and other health needs; recording and reporting to the supervisory health professional and case manager any changes in the recipient's physical condition, behavior, or appearance; infection control; and accompanying the recipient to approved recreational activities.

(b) A physician or Advanced Practice Nurse makes the determinations for the amount of personal care or similar services provided by a legally responsible individual in the form of a clinical and risk assessments, and an additional assessment form, which is used to assess the degree of assistance participants require. The determination of "extraordinary care" provided by a legally responsible individual exceeding the ordinary care that would be provided to a person without a disability of the same age is also made by a physician or an Advanced Practice Nurse.

(c) The controls employed to ensure that payments are only made for services rendered include PCA service limitations. The limitations on the amount of PCA services for which payment may be made shall not exceed sixteen (16) hours per day, up to seven (7) days per week. Additional limitations include: PCA services shall not include the requirement of a skilled licensed professional; shall not include tasks performed by chore workers; shall be provided at place of employment, in transit, in residence, and available 7 days per week; shall not be provided in a hospital, nursing facility, intermediate care facility; or institution for mental disease; and when services rendered include two employees from the same agency for different services, all RN visits shall be coordinated so that the supervisory in-home RN visits are in accordance with waiver standards and supervisory RN visits are made by the same supervising RN at the same time.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- (●) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The following processes are used to assure that all willing and qualified providers have the opportunity to enroll as Waiver providers. All qualified Waiver providers are accepted as providers of care. All criteria for Waiver providers are printed and available to any and all interested providers. This information is available online at www.dc-medicaid.com, as well as with the DHCF Office of Provider Services. **There are no time frames for providers to apply to become EPD providers. Once a provider application is submitted for approval, applicants have 30 days to return any requested information. If the information is not returned in 30 days, the application is returned to the provider and the applicant is welcome to reapply at any time in the future.** The 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 DHCF-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, 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), any sanctions from a regulatory agency, and business ownership.

3. The application is then sent to the DHCF Division of Long Term Care (DLTC) 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
• A copy of the business license
• A copy of Joint Commission certification
• The submission of any other documentation deemed necessary by DHCF for the approval process as a Medicaid-enrolled provider; additional requirements are Quality Improvement Plan, admission process, Code of Conduct, policies and procedures, and agency complaint process.
• Final steps in the application approval process entail application review by the DHCF committee: the Medical Director, the Office of the Agency 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 Agency Financial Officer 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 DLTC and retains a copy of the files. The original is sent to the Office of Provider Services, 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 DHCF within the specified timeframe, the application is returned to the provider as it is assumed he/she is no longer interested in providing services for the District of Columbia. He/she however, is given the opportunity to submit another application at their leisure.
• When the application is approved there is a Mandatory Provider orientation conducted by DHCF for programmatic and billing services.
• The orientations by DHCF 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.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
Number and percent of new provider applications, by type, who met EPD Waiver qualifications prior to the provision of services N:# of new provider applications who met EPD Waiver qualifications prior to the provision of services D:# of new

provider applications

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

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

Data Aggregation and Analysis:

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

☐ **Other**
Specify:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Health and Regulation and Licensing Administration (HRLA)Spreadsheet

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DHCF takes a plan of corrective action by internally developing and implementing a plan of corrective action when providers do not meet program measures and subsequently administering a deficiency report.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- [ ] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

- [ ] **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.

- [ ] **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
  Furnish the information specified above.

- [ ] **Other Type of Limit.** The State employs another type of limit.
  Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Elderly and Physical Disabilities Waiver

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- ☐ **Social Worker**

Specify qualifications:

- ☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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

- ○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Several safeguards are in place to promote appropriate service delivery and to guard against fraud, waste and abuse when a case management agency is also the agency delivering services. These include:

1. Prior Authorization – All EPD waiver services must be reviewed and prior authorized by a CMS Quality Improvement Organization (QIO) under contract to DHCF, which reviews clinical documentation supporting the need for the service submitted as part of the prior authorization request, and the appropriateness of the type and quantity of service(s) to be delivered. A waiver service may not be delivered without this prior authorization and claims submitted without an accompanying prior authorization are denied.

2. The beneficiary has direct access to DLTC EPPDB personnel and DC Ombudsmen – Both DC Medicaid program staff responsible for the management of the EPD waiver, and the DC healthcare Ombudsman are widely recognized and frequently used by beneficiaries, advocates, and other stakeholders to report any problems a beneficiary experiences with respect to case management or any part of service planning or delivery. DLTC EPDB personnel record these or requests for assistance in a log book, facilitating aggregation and analysis of issues. In addition, the health care Ombudsman and HCDMA (in particular the manager of DLTC) meet weekly to discuss problems reported to the Ombudsman to facilitate resolution of individual problems and implementation of system improvements where needed.

3. Concurrent and Retrospective Monitoring – In addition, EPDB staff and staff from DHCF's Division of Program Integrity / Surveillance and Utilization Branch perform concurrent and retrospective review of assessments, service plans, and overall compliance with waiver requirements of providers. When problems are detected, remediation is achieved as detailed elsewhere in this waiver.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Potential participants are made aware of the EPD Waiver and Waiver options through the Department of Health Care Finance (DHCF) website at website at: http://dhcf.dc.gov; the District of Columbia Office on Aging (DCOA) website at http://www.dcoa.dc.gov; the case manager from the identified case management agency, and word of mouth. The DHCF is currently developing a participant handbook about the EPD waiver.

The case manager (who is employed by the approved DHCF case management agency that the participant and/or family or legal representative has selected), ensures that during the assessment process he/she informs the participant and/or family or legal representative about his/her authority to include all individuals of his/her choice to participate in the service planning and development process. The case manager must also ensure that the Individual Service Plan (ISP) process is thoroughly explained and describes all support services available through the EPD Waiver program that could assist the participant, as appropriate, to successfully and safely live in the community. Furthermore, the case manager explains the role of the service provider agency to the participant in addition to providing him/her with the list of provider agencies that the participant can select from. The case manager and the participant discuss the appropriate service needs and frequency that each service will be provided. The discussion also entails the selection of the provider agency to provide each service. Finally, the case manager must inform the participant of his/her freedom of choice of providers during this initial meeting and at all subsequent meetings to include quarterly, mid-year and annual assessment and planning meetings, should a situation arise at any point which requires consideration of a provider change. The case manager also has the responsibility of ensuring that the freedom of choice of service and provider drives the planning process.

A standardized person-centered planning format is used throughout the planning development process. The service plan is developed by the Team of individuals which includes the participant his/her family/legal representatives (as appropriate), the case manager and others invited by the participant. These team members know and work with the participant and their active involvement is necessary to achieve the outcomes desired by the participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the

services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

SERVICE PLAN DEVELOPMENT AND TIMING:

The service planning process assures that participants have access to quality services and supports that promote independence, learning, growth; choices in everyday life; meaningful relationships with family, friends and neighbors, presence and participation in the fabric of community life; dignity and respect; positive approaches aimed at skill development; and health and safety. The planning process is driven by the participant’s vision, goals, and needs with overall management and facilitation provided by the Case Manager.

Potential participants, participants, and their legal representatives are informed of all available and approved EPD Waiver services during the initial contact with the Case Manager. Participants are again informed about each of the approved waiver services during the initial and subsequent (reevaluation and interim changes) service planning development process and as often as needed should any circumstance arise that may warrant an interest in needing new services and/or changing providers. Also during the initial contact and at least annually, Case Managers inform all participants that they can select any service provider they want including selecting a different provider for each service (if they choose to) without jeopardizing participation in the waiver and can request a change in services and/or provider at any time. The Case Managers provide all participants/their legal representative with and ensure that they complete the Freedom of Choice Forms for choice between waiver services and institutional care and choice between/among waiver services and providers.

In addition, the Case Manager also provides all participants and their representatives with the Department of Health Care Finance (DHCF) website at: http://dhcf.dc.gov and the District of Columbia Office on Aging (DCOA) website at http://www.dcoa.dc.gov where all of the waiver services are listed. Further, the DHCF is in the process of developing a participant handbook about the EPD waiver that will include all of the waiver services and the accompanying approved service providers for each service.

The Division of Long Term Care (DLTC) requires the case manager to confirm they have conducted a thorough assessment of the beneficiary and that the services requested adequately address the beneficiary’s functional limitations and other health needs.
The case manager or the case management provider agency contacts the participant/significant other to arrange for an initial visit within forty-eight (48) hours to complete the request for enrollment inclusive of the development of the ISP.

(a) The participant–centered service plan is developed by the participant and any other person(s) the participant chooses to be involved including family, friends and other advocates. The Case Manager is responsible for leading the development of the plan. However, he/she should assemble an interdisciplinary team for the plan development.
(b)The following types of assessments is 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) The case manager assists the participant in making decisions on what services may best meet the needs and goals of the participant.
(d) The plan is developed jointly by the participant with the case manager relying on clinical, environmental and social assessment information with participant’s shared goals, health care and other needs and preferences.
(e) 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 services 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.
(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:

(h) obtainment of a level of care determination;

(i) completion of the comprehensive participant assessment;

(j) Medicaid waiver services are selected by the participant and coordinated through the case manager who assist the participant

(k) development of the comprehensive ISP utilizing interdisciplinary team members participant and/or designee, family members and /or legal guardian;

(l) presentation of the completed ISP to customer and/or designee for acceptance of services;

(m) submission of the ISP for Agency approval;

(n) assisting the participant to select Medicaid service providers;

(o) ensuring proper implementation of services.

(p) 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.

Following completion of the annual service plan meeting the case manager submits to the physician the "Referral for Medical Level of Care (1728)" form for review and signature. Upon receipt of the approved 1728 the CM submits all documentation to the QIO for determination of a nursing facility level of care (LOC). The nursing facility level of care is a requirement to be eligible for the waiver program. The QIO reviews and approves the 1728 and issues a LOC which is then forwards to DHCF. DHCF prints and sends hard copies of the Annual POC Medicaid Waiver Recertification (1209), LOC, and the Proof of Income forms to the Economic Security Administration (ESA), formerly Income Maintenance Administration (IMA). ESA reviews the forms to determine the financial eligibility. IMA has forty-five (45) days to make a determination. ESA updates the program code in an electronic system which notifies DHCF electronic system to review for prior authorization. DHCF sends the QIO a task in Casenet to review for prior authorization. The QIO has seven (7) days from the receipt of the documentation to make a determination. The CM is responsible for ensuring that the waiver services are clearly delineated and justified based on upon the needs identified in the ISP and its accompanying assessments.

The case managers are required to conduct a quarterly comprehensive review to examine whether the ISP continues to satisfy the beneficiary's needs. Where the beneficiary's needs change, the case manager must update the beneficiary's ISP with changes to the plan of care and submit a change request form and supporting documentation to DHCF to authorize the change in services. Where the beneficiary's needs are found to remain the same, the case manager is required to sign and date the ISP to verify that the current ISP continues to meet the needs of the beneficiary. Monthly and quarterly the CM meets with the beneficiary and/or legal representative, family members, friends of the participant, and any other appropriate individual in the process to review and revise the service plan as appropriate. If there are any changes in the ISP identified during the annual review and/or at any time during the recertification period the changes will not be implemented until the ISP is approved (i.e.: change in the number of PCA hours for the participant to receive).
The annual renewal date changes if the participant does not recertify before the expiration of the recertification period and the participant loses their Medicaid eligibility.

ASSESSMENTS:
Personal interviews are conducted with each applicant/beneficiary. During the initial visit several assessments are completed and entered into the electronic system (Casenet). The CM will explain the following assessments that will be completed to comprise a comprehensive assessment:
(1) A clinical assessment which includes the identification of the beneficiary's social, medical, physical, psychological and mental needs.
(2) An environmental assessment that entails the identification of any areas that may need adjustments (i.e.: ramps, chairlifts, etc.) to ensure there is a safe environment.
(3) An assessment of the available support systems that are in place for the beneficiary. The assessments are completed as part of the intake and eligibility process for all applicants/beneficiaries. All assessments are completed utilizing the standardized tools in the Casenet system. The client health history includes the documentation of the Risk Assessment. The CM discusses with the beneficiary/significant other their goals for the beneficiary and their

expectations from the services offered through the EPD waiver program. During the assessment phase of the visit the CM will discuss recommendations for which services will be available and appropriate to include the frequency of each service identified.

HOW PARTICIPANTS ARE INFORMED OF AVAILABLE SERVICES
Potential participants, participants, and their legal representatives are informed of all available and approved EPD Waiver services during the initial contact with the Case Manager. Participants are again informed about each of the approved waiver services during the initial and subsequent (reevaluation and interim changes) service planning development process and as often as needed should any circumstance arise that may warrant an interest in needing new services and/or changing providers. Also during the initial contact and at least annually, Case Managers inform all participants that they can select any service provider they want including selecting a different provider for each service (if they choose to) without jeopardizing participation in the waiver and can request a change in services and/or provider at any time. The Case Managers provide all participants/their legal representative with and ensure that they complete the Freedom of Choice Forms for choice between waiver services and institutional care and choice between/among waiver services and providers.
In addition, the Case Manager also provides all participants and their representatives with the Department of Health Care Finance (DHCF) website at: http://dhcf.dc.gov and the District of Columbia Office on Aging (DCOA) website at http://www.dcoa.dc.gov where all of the waiver services are listed.

INCORPORATION OF PARTICIPANT GOALS/NEEDS/PREFERENCES IN PLAN
The service plan must incorporate the following required components:
1.The participant's prioritized personal outcomes and specific strategies to achieve or maintain the desired personal outcomes, focusing first on informal and community supports and, if needed, paid formal services.
2. An action plan which will lead to the implementation of strategies to achieve the identified desired personal outcomes, including action steps, review dates and timelines and the responsible individual for each identified action, ensuring that the steps which are incorporated empower and enable the participant to develop independence, growth, and self-management;
3. Target dates for the achievement/maintenance of personal outcomes;
4. Identify the preferred formal and informal service providers and specification of the service arrangements;
5. Identify who will assist the CM in planning, developing, and implementing supports or directs the services; and
6. Ensures participants and all team members sign attesting to their agreement to participate in the implementation of the participant's service plan and that the participant's goals, needs, including health care and preferences are addressed.

COORDINATION OF WAIVER SERVICES
The CM will assist with the coordination of all services including waiver and non-waiver services identified as a need to ensure the health and safety of the participant to remain in the community setting. The CM will contact the selected direct care providers and discuss the number of hours the participant is assessed to need. The CM will ensure that the participant is aware of when to being delivered as requested and approved. The CM will ask the participant/significant other in reference to their satisfaction with the
services received.

The CM will conduct the required monthly visits and review the service plan, track monthly progress of identified goals and timelines, and get updated information on the progress of informal/unpaid supports, if any, identified in the support plan. A case management Monitoring Tool is completed during each visit to ensure all information is captured and will be entered into Casenet.

The participant and his/her legal representative may contact the CM and/or CM agency at any time for assistance. Formal monthly contacts offer an opportunity for the participant to request meetings and make formal revisions to the service plan and for the CM to determine if a reassessment is needed based on the participant's wellbeing.

ASSIGNMENT OF RESPONSIBILITIES TO IMPLEMENT AND MONITOR PLAN
The CM is responsible to implement and monitor the ISP for effectiveness of the responsibilities fulfilled by the different disciplines monthly and quarterly. The RN will be responsible to provide supervision and evaluation of any service requiring RN intervention, ex. PCA, on a monthly and document clinical notes in reference to the participant's health monthly and quarterly. The physician will be responsible to approve the plan of care every six months. The PERS provider will be responsible for developing an ISP annually describing the responsibilities of the company and submitting to the CM for review and approval. The CM will be responsible to review and approve the PERS ISP, annually. The RN will be responsible for developing annual assignments for the PCA and reviewing the assignment with the participant, his/her chosen team members, and the PCA. The PCA will be responsible to provide care as outlined in his/her assignment and the ISP.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Health Risk Assessment and Mitigation Plan efforts are conducted on admission (the initial visit) to identify, analyze and prioritize risks associated with the beneficiary's conditions which will impact the provision of EPD Waiver Services. The application of this Risk Assessment is incorporated in the clinical health assessment. A Risk Management Plan and a corresponding proposed action (mitigation) plan will be developed and implemented for identified risks. The ISP will address any and all of the identified risks resulting from the comprehensive health clinical health assessment. Described in the ISP will be what each service provider will do to try and avoid any negative outcomes from the identified risk factors.
Purpose: The purpose of the risk assessment is to react to events that could occur and may impact upon the scope and delivery of services. Risks are measured in terms of their likelihood of occurrence and their impact of the beneficiary as well as the Waiver services.

Objective: To ensure that the perceived risk and scope are proactively identified, communicated and mitigated in a timely manner.

Each provider agency CM should ensure there are contingency plans (back-up plans) in case of emergency situations. There shall be a designated person to contact in case of emergency. All staff that provides direct care shall be well versed (current in certification as applicable) in emergency techniques such as CPR and the individualized contingency/back-up plans. All contingency plans shall be documented in the ISP and a copy of the plan should be in the beneficiary's home where it is readily accessible.

The contingency/back-up plans will be developed with the case manager, beneficiary, and any person that the beneficiary identifies need to have input in the decision making of the plan. Some types of contingency/back-up plans are: a designated person to be responsible for the care of the beneficiary in case there is no PCA available to provide care for a specified shift in case of a call-in; a designated person to be responsible for the care of the beneficiary every day when the PCA leaves if the beneficiary receives 16 hours per day of care by a PCA; in case there is a massive snow storm and no PCA can get to the benefciary's home to assist the beneficiary; and the case management ensuring and assisting with placing the beneficiary's name on the list the that the fire department uses to know which individuals will need assistance evacuating in case of a fire (the list is called the CAD List which stands for Computerize Aided Dispatch).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

All providers should inform and remind the beneficiary of the freedom of choice in the selection of all providers at all meetings/visits/telephone calls as needed. The case manager informs applicants and beneficiaries about freedom of choice of providers for each service.

Potential beneficiaries are made aware of the EPD Waiver providers and services through DHCF brochures, DC Office on Aging and Community Outreach, the provider listing, the Aging and Disabilities Resource Center (ADRC), DHCF website (http://dhcf.dc.gov), Ombudsman Office, during each visit form the RN/CM/PCA, as well as word of mouth. The case manager informs applicants and beneficiaries about all services at initial and subsequent meetings.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which

the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The process for the approval of the ISP is:
1. The CM submits the completed documentation in Casenet, the electronic record system, for determination of a nursing facility level of care (LOC) by the QIO.
2. If the QIO has questions or needs additional information the QIO will request the information by way of a task to the CM.
3.If no additional information is needed or when all information is received then the QIO will provide approval of a LOC for one (1) year.
4.The QIO task DHCF the approval of the LOC
5.The DHCF forwards the information to IMA for financial eligibility determination.
6.ESA reviews the documentation and approves the applicant for one year for the EPD waiver program or disapproves the applicant for the EPD waiver program.
7.The documentation of the program is then forwarded to DHCF if approved for the EPD waiver program through ESA electronic system to DHCF electronic system. If the documentation is not approved for the EPD waiver it is documented in ESA electronic system and ESA notifies the applicant about the determination of which if any programs the applicant qualifies for.
8.DHCF forwards the information to the QIO for approval.
9. Once all information is received and the QIO review of the documentation yields positive results (no additional information needed) the QIO approves the documentation and provides an authorization number.
The DHCF reviews annually a percentage of all EPD Waiver provider agencies records.
1. The DHCF reviewed 10% of each agencies current EPD Waiver census clinical records.
2. The DHCF reviewed for compliance with the EPD Waiver regulations, district and federal regulations and the provider agency policies and procedures,
3. Deficiency statements are written with a request for a plan of correction,
4. The plan of correction is reviewed and accepted as appropriate.
The DHCF will utilize a different methodology for selection of record review to be effective prior to the end of the calendar year 2011 to ensure the sample size is statiscally valid.

Documentation reviewed by DHCF staff:
• Individual Service Plan
• Client Health history (the risk assessment is incorporated in this form)
• Waiver Service Cost Sheet
• Signed Beneficiary Freedom of Choice
• Bill of Rights
• Environmental Assessment
• Individual Service Plan Agreement
• 2010-1
• LOC
• 30AW Form

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ◉ **Other schedule**

Specify the other schedule:

The ISP is reviewed initially, quarterly, annually and revised as necessary.

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a

minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- [x] **Medicaid agency**
- [ ] **Operating agency**
- [x] **Case manager**
- [x] **Other**

Specify:

Service plans are kept by the home health provider agencies and DHCF maintains copies of the service plans in Osenet, the EPD HCBS information system.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

All providers should inform and remind the beneficiary of the freedom of choice in the selection of all providers at all meetings/visits/telephone calls as needed.

DHCF is responsible for monitoring the implementation of the ISP. The monitoring is completed at a minimum of annually. A review of the documentation in the electronic record, complaint/incident binders and interviews is the method used by DHCF to determine whether services are furnished in accordance with the service plans; beneficiaries have access to waiver services identified in the ISP; services meet the needs of the beneficiaries; back-up plans are effective; beneficiary health and welfare is assured; beneficiaries exercise freedom of choice of providers; and beneficiaries have access to non-waiver services if identified in the ISP. Review of documentation and submission of requested reports is the method used to ensure follow-up to identified problems. DHCF keeps documentation of all deficiency reports annually electronically.

• The case management agency is responsible for monitoring the staff and contractors to ensure the implementation of the ISP and the health and welfare of the beneficiary. DHCF is responsible for monitoring the case management agency to ensure the ISP was implemented and the health and welfare of the beneficiary.
• DHCF monitors the case management provider agency at a minimum annually.
• The monitoring and follow-up methods that are uses by DHCF are as follows. The DHCF makes unannounced visits to the provider agency. DHCF conducts an entrance conference to explain the purpose of the visit and inform the provider agency of the documentation that will be needed to complete the annual monitoring visit. The DHCF request a copy of all current EPD waiver beneficiaries (i.e.: census) to randomly select a percentage of the beneficiaries' clinical records to review. DHCF will also request to review records of beneficiaries that had voiced complaints about the provider agencies as appropriate. DHCF also conducts interviews of the staff as appropriate. DHCF reviews personnel files, complaint/incident binders and policies/procedure manuals. After review of the clinical records is completed DHCF selects a sample of the records reviewed to visit the beneficiaries homes. DHCF request that the provider agency staff calls the beneficiaries and arrange for the DHCF to make a home visit. DHCF meets with the provider agency and conducts a verbal exit conference. The purpose of the visit is to determine the provider agency's compliance with the EPD waiver regulations, district and federal regulations and the agency's policies and procedures. Also the visits to the beneficiaries' homes will allow the DHCF to assess the beneficiaries satisfaction with the services received from the provider agencies.
• After completion of the on-site visit the DHCF will return to the office and complete a statement of deficiencies (SOC) as appropriate. The SOC will be forward to the provider agency by mail, e-mail or pick-up by the agency. The agency will have fifteen (15) days to return a plan of correction.
• DHCF will provide the agency with an acceptance letter of approval of the POC. If the POC is not acceptable (i.e.: lack of documentation describing how the deficiency will be corrected and plans to alleviate recurrence of the identified deficient area) the DHCF will notified the agency and request a revised POC.

b. Monitoring Safeguards. *Select one:*

- [ ] **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

tities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

DHCF ensures the monitoring is conducted in the best interests of the beneficiary by completion of the annual on-site visits to the providers and beneficiaries, if needed. The visits entail review of documentation, interviews of staff and beneficiaries' home visits. Monitoring and onsite visits may occur upon notification of any suspected fraud, abuse, or waste.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Number and percent of waiver beneficiaries who have service plans that address their needs as indicated by the supporting assessment documentation. N:# of waiver participants who have service plans that address their needs D:# of beneficiaries reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 enrollees chosen at random using automated random selection programs (i.e., RATSTAT or MMIS adjunct software).
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

Number and Percent of waiver participants who have service plans that address their personal goals N:# of participants who have service plans that address their personal goals D:# of participants reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 enrollees chosen at random using automated random selection programs (i.e., RATSTAT or MMIS adjunct software).
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and Percent of waiver participants who have service plans that address their health and safety risks N: # of beneficiaries service plans that address health and safety risks D:# of waiver beneficiaries service plans reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 enrollees chosen at random using automated random selection

		programs (i.e., RATSTAT or MMIS adjunct software).
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Casenet

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and Percent of participant ISPs that contain the case manager and beneficiary signature indicating authorization. N: # of participant ISPS that contain the case manager and beneficiary signature D:# of participants reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 enrollees chosen at random using automated random selection programs (i.e., RATSTAT or MMIS adjunct software).
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

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

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

Performance Measure:
Number and percent of individuals whose ISP was reviewed and revised before the waiver participant's reassessment date N:# of individuals whose ISP was reviewed and revised before the assessment date D:# of participants reviewed

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

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

		Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 enrollees chosen at random using automated random selection programs (i.e., RATSTAT or MMIS adjunct software).
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of individuals whose ISP was revised, as needed, to address changing needs. N:# of individuals whose ISP was revised as needed to address changing needs D:# of participants reviewed

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

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

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 enrollees chosen at random using automated random selection programs (i.e., RATSTAT or MMIS adjunct software).
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Omnicaid

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

	Ongoing	Specify: Quarterly convenience sample of 30 enrollees chosen at random using automated random selection programs (i.e., RATSTAT or MMIS adjunct software).
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants whose records contain an appropriately completed and signed freedom of choice form that specifies choice was offered between institutional care and waiver services N:# of participants whose records have a signed freedom of choice form D:# of participants reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 enrollees chosen at random using automated random selection programs (i.e., RATSTAT or MMIS adjunct software).
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of waiver participants whose records contain an appropriately signed ISP documentation of agreement showing choice of provider and services N:# of waiver participants with signed ISP documentation of agreements indicating choice of providers and services D:# of participants reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 enrollees chosen at

		random using automated random selection programs (i.e., RATSTAT or MMIS adjunct software).
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Medication administration data reports, logs
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Quarterly convenience sample of 30 enrollees chosen at random using automated random selection programs (i.e., RATSTAT or MMIS adjunct software).
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by

the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
DHCF will use multiple strategies to discover/identify problems/issues including: 1)monthly compilation and analysis of complaints received from waiver enrollees, providers, and other stakeholders by a)the Division of Long Term Care's Elders and Persons with Disabilities Branch, b) District of Columbia Health Care Ombudsman (via weekly meetings), and c) from the organization contracted by DHCF to perform prior authorization of waiver services. This compilation and analysis will be performed by staff in the Division of Long Term Care's Elders and Persons with Disabilities Branch. In addition, annual feedback will be given to the Division of Long Term Care's Elders and Persons with Disabilities Branch from DHCF's Utilization Management unit based on their annual chart reviews of EPD waiver providers. Finally, Division of Long Term Care's Elders and Persons with Disabilities Branch will conduct monthly on-site reviews of patient care documentation and service delivery.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Provider-focused remediation include:

1) Meeting with providers (individually or as a group) to deliver education to correct the detected problems. This will most often be used for a first-time occurrence of a problem of a specific type. Meetings will be conducted by staff from DHCF's Elders and Persons with Physical Disabilities Branch. If a problem is detected across multiple providers, DHCF will send an official written transmittal to all providers describing the problem and how DHCF requires it to be addressed. Documentation of these efforts will be made by DHCF's Elders and Persons with Physical Disabilities Branch as notes on individual providers, notes on the agenda of monthly provider meetings, or as copies of the transmittals.
2) Problems that recur will be addressed through additional training and the delivery of a written notice from DHCF requiring the correction of the problem. DHCF's Elders and Persons with Physical Disabilities Branch is also responsible for written communication with individual providers and will retain documentation of such.
3) Problems that persist will be addressed through more stringent means including the recoupment of Medicaid payments associated with claims related to the service plan problem. Such recoupments are handled by DHCF's Office of Utilization Management which maintains documentation of all such recoupments.
4) Serious and /or repeated violation of standards for service planning can result in termination of the provider in accord with DHCF's Administrative regulations. Provider Terminations are handled by DHCF's Office of Program Integrity which maintains documentation of all such provider actions.

ii. Remediation Data Aggregation

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

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

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

EPD waiver participants will have the opportunity to: 1) recruit, hire supervise and discharge qualified direct care workers who perform personal care services under the category of participant-directed Personal Care Services (Employer Authority) and 2) purchase allowable Individual-directed Goods and Services using a participant-directed individual budget (Budget Authority). Vendor F/EA FMS and Supports Broker services will be provided as administrative services by one District-wide Vendor F/EA FMS/Supports Brokerage entity selected through an RFP process.

Participants who choose to participant-direct their services will have access to other services available under the traditional HCBS waiver delivery option. Thus participants may elect to receive either traditional HCBS or participant-directed HCBS or a combination of both. Duplication of services will not occur.

How Participants Access Participant-Directed Services:
Current EPD waiver participants and new enrollees will have the opportunity to elect the new participant directed option.

Existing Waiver Participants - The traditional case manager will inform every current waiver participants about the new option. All current beneficiaries will have the option to choose to participant direct and develop a new ISP that includes participant directed services. Case managers will be required to hold a meeting with all current EPD waiver

participants to provide them with comprehensive, easily understood information about the participant-direction option. During this meeting, the case manager will discuss options to ensure that each waiver applicant understands the different opportunities available under the traditional HCBS and participant direction. If the participant chooses to participant-direct, all duties of the case manager are transferred to the supports broker, including developing a new ISP that is applicable to the meet their participant-directed service needs. All current EPD waiver participants must sign a form indicating that the case manager provided adequate information about the option that prepared them fully to determine whether to choose to participant-direct, and also provide contact information for the Vendor F/EA FMS/Supports Brokerage entity if the participant had additional questions. Forms from all current EPD waiver participants will be due to OCLTC within 60 days of participant-direction program implementation.

New Enrollees – New enrollees who enter the system through the traditional Medicaid system may meet with a case manager. During the initial assessment, applicants will be provided information about the participant-direction option. Case managers will be required to provide all new EPD waiver participants with comprehensive, easily understood information about the participant-direction option. DHCF will approve educational materials used, and will hold several trainings for case managers prior to participant-direction implementation about this new option. New participants will sign a form indicating that the case manager provided adequate information about the option that prepared them fully to determine whether to choose to participant-direct, and also provide contact information for the Vendor F/EA FMS/Supports Brokerage entity if the participant had additional questions. This form will be part of the required documentation in the initial EPD waiver form

If a new EPD waiver participant chooses to participant direct at enrollment, he/she will work directly with the supports broker, who will conduct the initial assessment and develop the ISP following that.

Entities Supporting Individuals:
The Vendor F/EA FMS/Supports Brokerage entity selected through an RFP will work with participants to provide support services to ensure that they are successful in using participant directed services. The Vendor F/EAFMS/Supports Brokerage entity will provide both Vendor F/EA FMS and Supports Brokerage services as described below.

Supports Brokerage Services Provided by Supports Brokers - Once a waiver participant selects the participant directed option, he/she will be assigned to a supports broker. Each supports broker must attend training and be certified by the Vendor F/EA FMS Supports Brokerage entity to provide Supports Brokerage services. The Vendor F/EA FMS Supports Brokerage entity will verify qualifications for all supports brokers. Supports brokers must meet the qualifications required of case managers as described in the original waiver in addition to qualifications necessary to perform other functions to assist participants in directing their services. The supports broker will work with the participant to develop an ISP. The ISP will include an assessment of the participant's needs, goals and preferences. Once the ISP is developed and approved by DHCF and the participant's individual budget is authorized, the supports broker and the participant will begin implementation. The supports broker also will manage the re-certification of participants' ISPs. During the implementation and management of the ISP, the supports broker will:
• Advise and provide information, assistance and support the participant/representative, as needed and necessary;
• Assist participants/representatives with the development and execution of their participant-directed individual budget and track expenditures;
• Assist participants/representatives with the development of an emergency back-up plan;
• Assist participants/representatives identify risks and develop a written plan to manage those risks;
• Provide participants/representatives with employer skills training related to recruiting, interviewing, hiring, training, developing work schedules, managing, and/or dismissing workers their workers
• Orient participants/representatives in using participant-directed services, the Vendor F/EA FMS/Supports Brokerage entity and being the common law employer of their workers;
• Assist participants/representatives in negotiating payment rates and benefits;
• Verify accuracy of documentation required;
• Assist with monitoring health and welfare to the extent required of a mandatory reporter;
• Refer participants for additional assessments and/or reassessments;
• Assist participants /representatives in making decisions about purchasing individual-directed goods and services; and
• Assist participants/representatives in resolving issues as they may arise.

Vendor Fiscal/Employer Agent (F/EA) Financial Management Services (FMS) - The Vendor F/EAFMS/Supports Broker entity will operate in accordance with §3504 of the IRS, Rev. Proc. 70-6 and 1/13/2010 Notice of Proposed Rulemaking §3504 Agent Employment Tax Liability and Federal and District program, labor, workers' compensation and US Citizenship and Immigration Services requirements. In addition, the entity will offer the following Vendor F/EA FMS services:
• Prepare and maintain a DC-specific Vendor F/EA FMS Policies and Procedures Manual in an electronic format and

update at least annually and more often, as necessary;
• Stay up-to-date with all federal and state program, labor, tax, workers' compensation insurance and citizenship and alien status requirements related to household employers , Vendor F/EA FMS and Supports Brokerage providers;
• Receive and disburse participants' individual budget funds and monitor and manage participants,
• Manage participant-directed individual budget funds, including monitoring participant spending of public funds and any over and under spending in accordance w/ his/her approved;
• Prepare and distribute participant enrollment and qualified direct care worker employment and goods and service vendor enrollment packages and collect and process required information from each package;
• Conduct criminal background checks on prospective qualified direct care workers;
• Report newly hired qualified workers with the DC New Hire Reporting System,
• Verify workers and vendors qualifications as determined by OCLTC;
• Distribute and collect qualified workers' time sheets, verify against participants' individual budgets and process for payroll;
• Verify wages paid to qualified workers are in accordance with Federal and District department of labor laws;
• Withhold, file and pay federal and District income tax withholding and employment taxes (FICA, FUTA and SUTA);
• Manage garnishments, liens and levies against qualified workers' wages;
• Manage federal advanced earned income credits for eligible qualified workers;
• Prepare and distribute payroll checks to qualified workers;
• Process IRS Forms W-2 and any District year-end tax reconciliations;
• Process refunds of over collected FICA (employer portion back to DHCF and the employer portion back to the direct care worker) when appropriate;
• Process any returned payment per District Unclaimed Property law, when necessary;
• broker workers' compensation on behalf of the participant or representative, when available;
• Process and pay invoices for approved individual-directed goods and services as authorized in the participants' individual budget;
• Provide Supports Broker with training in accordance with OCLTC standards;
• Develop a transition plan to allow for no disruption of services for beneficiaries who are
• Prepare and distribute a monthly statement of waiver expenditures and balances for participants and representatives with a copy to the supports broker and OCLTC ;
• Prepare and distribute required utilization and waiver expenditure reports to OCLTC, as required;
• Execute Medicaid provider agreements as authorized under a written agreement with the District's Medicaid agency and maintaining them on file; and
• Provide a customer service system that provides for a toll free phone number and fax, a TYY or another mechanism to communicate with individuals with hearing impairments; interpreter capabilities including foreign language and American Sign materials in available alternate formats; and have a system to receive, track and respond to participant/representative calls and complaints including a system for referring issues as a mandatory reporter.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements**

where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

○ **Waiver is designed to support only individuals who want to direct their services.**

◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

All EPD waiver participants will receive information about using participant-directed services. The information will include printed materials that include a description of the benefits and participants'/ representatives' rights, responsibilities and potential liabilities related to using participant-directed services, and the role, responsibilities and potential liabilities of the Vendor F/EA FMS/Supports Brokerage entity. In particular, the information will explain the roles and duties of the Vendor F/EA FMS/Supports Brokerage entity related to managing the administrative services, and to what extent the entity may work directly with participants' qualified workers and vendor providers. The information will include the Vendor F/EA FMS/Supports Brokerage entity's hours of operation and contact information. The Vendor F/EA FMS/Supports Brokerage entity will provide information in alternative formats for individuals with sight and hearing impairments, and have foreign language capabilities including American Sign Language.

DHCF will send the information to all current EPD waiver participants. This information will also be included in updated and applicable DHCF publications and the public DHCF Internet site: http://dhcf.dc.gov/dhcf/site/default.asp , the ADRC websites, and at all ADRC locations. ADRCs will hold frequent informational meetings about this new option.

As described above, case managers must educate all current and new enrollees who enter the system through the traditional Medicaid waiver about participant-direction and providing this information. For new enrollees who enter

the system through the Vendor F/EA FMS/Supports Brokerage entity immediately, the supports brokers will be responsible for explaining how participant direction works and for providing this information. In addition, the Vendor F/EA FMS/Supports Brokerage entity will create enrollment and qualified direct care worker employment and vendor provider enrollment packets for new enrollees that choose participant-direction to receive when they first register with the Vendor F/EA FMS/Supports Brokerage entity.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☐ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The following safeguards are utilized to ensure the participant's health, safety and welfare: The participant may choose a representative consistent with the District of Columbia rules governing participant-appointed representatives. The District EPD Waiver rules covering personal care aides include non-spouse providers of care, as well as neighbors or relatives. All decisions made by non-legal representatives shall correlate to the participants' individual support plan (ISP). Steps are taken to insure that the decisions made will be based on the participants' best interests. Spouses or others designated by the participant can provide care and be paid for that care providing they meet all rules and guidelines associated with EPD waiver and qualified direct care worker requirements as outlined below:

Qualified direct care workers and the personal care service providers are private individuals recruited, hired, supervised, managed and dismissed by the participant. Qualified direct care workers can only be paid at the maximum allowable rate for a personal care provider. Qualified direct care workers must have demonstrated the skills necessary to meet the customer's needs. The supports broker is responsible for verifying that the provider has the training, education and experience required to perform the tasks. Training requirements are specified in the service description below.

All persons performing personal care services must:
a. Be 18 years of age or older;
b. 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. Code, d32-1351 et seq.);
c. Sign a home and community-based service provider contract or agreement with the Department (delegated to the Vendor F/EAFMS/Supports Brokerage entity) to provide services to waiver recipients;
d. Complete minimum training requirements prior to service, and any additional training requirements outlined in the Individual Service Plan (ISP) within 30 days of beginning service;
e. Be free of any communicable diseases; and
f. Be, in the supports broker's judgment, able to foster a healthy, working relationship with the waiver recipient.

Training Requirements:

1. All persons performing personal care services must meet training plan requirements specific to the individual customer as specified in the ISP.

2. The qualified direct care worker must receive a certificate from the Medicaid office or its delegate

(Vendor F/EA FMS/Supports Brokerage entity) indicating that the minimum training plan as described in the participant's ISP was successfully completed before services are provided to a Medicaid recipient, and any additional requirements were completed within 30 days of service state date.

3. The training plan must include:
• Minimum Requirements:
o CPR
o First aid/vital signs/emergency
o Information about how to ensure participant's rights, autonomy and community inclusion
o DHCF, DDS and/or Vendor F/E A administrative procedures and requirements
• Additional requirements as described in the ISP
o ADLs/IADLs training based on participant's ISP

4. The waiver participant may provide training to the personal care provider in the health-related tasks that the customer self-directs in addition to training required by the DLTC and the Vendor F/EAFMS/Supports Brokerage entity.

5. Qualified direct care workers may be exempt from portions of the health and patient care-related training requirements such as CPR and first aid if he/she can:
a. Provide documentation and/or license or certification that they have received training in CPR and/or first aid emergency care and/or specific skills required of an direct care worker by the participant;
b. If they are a:
(1) Personal care worker;
(2) Certified nursing assistant; or
(3) Home health aide; or
(4) Personal care provider
The Vendor F/EA FMS-Supports Broker entity will determine if a qualified direct care worker may be exempt from training requirements, and DLTC will approve or disapprove the exemption based on documentation of the f the above examples for exemptions that must be maintained within the waiver participant's case file.
c. Applicability of the services is consistent with the rules of the Personal Care Aide and has been added to the service rules.

6. Where an EPD waiver participant is willing and in the supports broker's judgment capable of providing any parts of the required training, the supports broker should empower the customer to do so. However, all of the following must be adhered to when the participant is designated to conduct components or the provider training:
a. Any such decision shall be agreed upon by the participant and documented in the ISP
b. There must be a list of areas of training provided by the customer, signed by the customer and kept in the file of the case manager or provider agency;
c. Of the required training components, the ISP must clearly identify how each is to be addressed by the participant, and/or by another trainer.

Additional requirements:

The qualified direct care worker must:
1. Understand the individualized service plan (ISP);
2. Contact the participant's representative and supports broker when there are changes which affect the care outlined in the ISP
3. Observe the participant for change(s) in health, take appropriate action, and respond to health-related emergencies;
4. Notify the supports broker/ case managers immediately when the customer enters a hospital, or moves to another setting;
5. Notify the supports broker immediately if the participant dies;
6. Notify the designated participant and/or representative if applicable at least twenty four hours ahead of scheduled time when unable to serve the participant; and
7. Notify DHCF and designated employer when the provider will no longer provide services. Notification to the customer/ legal guardian must:
a. Give at least two weeks' notice, and
b. Be in writing.

8. In addition to the above requirements, the qualified direct care worker must

a. Complete and keep accurate timesheets that are accessible to the supports broker or individual providing supervision.

b. Maintain certain employment standards, which include:

1. Maintaining a drug and alcohol free work place;
2. Absence of criminal activity;
3. Skills, knowledge, ability, and willingness to provide the services.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Participant-Directed Personal Care Services	☑	☑
Participant Directed Goods and Services		☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The Vendor F/EA FMS/Supports Brokerage entity is reimbursed for the provision of F/EA FMS and Supports Brokerage services with per-member-per-day rates. The total payment amount varies by EPD waiver participant and is comprised of one rate for Vendor F/EA FMS, and one or more rates Supports Brokerage (information/assistance /counseling) services.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The Vendor F/EAFMS/Supports Brokerage entity may receive additional payments for one-time ad hoc services, such as developing enrollment packages prior to implementation. As part of the RFP process, vendors bidding will be required to submit a cost proposal that will propose rates for F/EA FMS and Support Brokerage services. Actual F/EA FMS and Supports Brokerage service rates will be determined by the vendor awarded the contract and based on DHCF approval.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [x] **Other**

Specify:

Vendor Fiscal/Employer Agent (F/EA) Financial Management Services (FMS) - The Vendor F/EAFMS/Supports Broker entity will operate in accordance with §3504 of the IRS, Rev. Proc. 70-6 and 1/13/2010 Notice of Proposed Rulemaking §3504 Agent Employment Tax Liability and Federal

and District program, labor, workers' compensation and US Citizenship and Immigration Services requirements. In addition, the entity will offer the following Vendor F/EA FMS services:
• Prepare and maintain a DC-specific Vendor F/EA FMS Policies and Procedures Manual in an electronic format and update at least annually and more often, as necessary;
• Stay up-to-date with all federal and state program, labor, tax, workers' compensation insurance and citizenship and alien status requirements related to household employers , Vendor F/EA FMS and Supports Brokerage providers;
• Receive and disburse participants' individual budget funds and monitor and manage participants,
• Manage participant-directed individual budget funds, including monitoring participant spending of public funds and any over and under spending in accordance w/ his/her approved;
• Prepare and distribute participant enrollment and qualified direct care worker employment and goods and service vendor enrollment packages and collect and process required information from each package;
• Conduct criminal background checks on prospective qualified direct care workers;
• Report newly hired qualified workers with the DC New Hire Reporting System,
• Verify workers and vendors qualifications as determined by DLTC;
• Distribute and collect qualified workers' time sheets, verify against participants' individual budgets and process for payroll;
• Verify wages paid to qualified workers are in accordance with Federal and District department of labor laws;
• Withhold, file and pay federal and District income tax withholding and employment taxes (FICA, FUTA and SUTA);
• Manage garnishments, liens and levies against qualified workers' wages;
• Manage federal advanced earned income credits for eligible qualified workers;
• Prepare and distribute payroll checks to qualified workers;
• Process IRS Forms W-2 and any District year-end tax reconciliations;
• Process refunds of over collected FICA (employer portion back to DHCF and the employer portion back to the direct care worker) when appropriate;
• Process any returned payment per District Unclaimed Property law, when necessary;
• broker workers' compensation on behalf of the participant or representative, when available;
• Process and pay invoices for approved individual-directed goods and services as authorized in the participants' individual budget;
• Provide Supports Broker with training in accordance with DLTC standards;
• Develop a transition plan to allow for no disruption of services for beneficiaries who are
• Prepare and distribute a monthly statement of waiver expenditures and balances for participants and representatives with a copy to the supports broker and DLTC ;
• Prepare and distribute required utilization and waiver expenditure reports to DLTC, as required;
• Execute Medicaid provider agreements as authorized under a written agreement with the District's Medicaid agency and maintaining them on file; and
• Provide a customer service system that provides for a toll free phone number and fax, a TYY or another mechanism to communicate with individuals with hearing impairments; interpreter capabilities including foreign language and American Sign materials in available alternate formats; and have a system to receive, track and respond to participant/representative calls and complaints including a system for referring issues as a mandatory reporter.

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.

DLTC monitors and assesses the readiness and performance of the Vendor F/EA FMS/Supports Brokerage entity through a number of monitoring activities. DLTC conducts a Vendor F/EA FMS/Supports Brokerage Readiness Review prior to the contract being finalized and services being implemented. DLTC also conducts an Annual Vendor F/EA FMS/Supports Brokerage Quality Assessment and Performance Review using the methods described earlier in Appendix A (5) & (6). The Health Care Delivery Management Administration's (HCDMA) Division of Quality and Health Outcomes (DQHO) addresses other quality assurance related issues as they arise. The DLTC also contacts a sample of EPD waiver participants that choose to participant and/or representative directly 90-120 days after election and conducts satisfaction survey. A participant satisfaction survey targeting a sample of participants and/or representatives is part of the Annual Vendor F/EA FMS/Supports Brokerage Quality Assessment and Performance Review.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case management services assist in provision of coordination of all Waiver services, including participant directed services, provided to participants so that services are delivered in a well coordinated, safe, timely and cost-efficient manner that addresses the specific needs of the participant.

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:

• Activities associates with the customer to access waiver services. These activities include obtainment of a level of care determination and financial eligibility documentation
• Completion of the comprehensive customer assessment,
• Development of the comprehensive ISP utilizing interdisciplinary team members, customers 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; implementation of services.
• Assisting the participants select service providers
• Assisting participants with securing necessary physician orders when required for the initiation of and service providers
• Assisting participants 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 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.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage

Chore Aide	☐
Participant-Directed Personal Care Services	☑
Participant Directed Goods and Services	☑
Case Management	☑
Personal Care Aide	☐
Homemaker	☐
Environment Accessibility and Adaptation Services	☐
Assisted Living	☐
Personal Emergency Response System (PERS)	☐
Respite	☐

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

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

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.

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.

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:

• Activities associates with the customer to access waiver services. These activities include obtainment of a level of care determination and financial eligibility documentation
• Completion of the comprehensive customer assessment,
• Development of the comprehensive ISP utilizing interdisciplinary team members, customers 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; implementation of services.
• Assisting the participants select service providers
• Assisting participants with securing necessary physician orders when required for the initiation of and service providers
• Assisting participants 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 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.

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;

Appendix E: Participant Direction of Services

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k. Independent Advocacy *(select one)*.

- (•) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Participants/representatives have the opportunity to terminate their use of participant-directed services at any time and may terminate with one week notice. Once they have terminated their use of participant-directed services, participants/representatives may reconsider their decision to terminate using participant-directed services after three

months. EPD Waiver participants may choose agency sponsored services at any time. No break in service will occur.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The District will secure technical assistance from a CMS contractor to get assistance with developing the required framework needed to operationalize Participant Directed Services and will submit an amendment upon completion of the policies and procedures needed to effect these services.

If DLTC identifies an instance where the participant-direction is not in the best interest of the participant and corrective action (additional training, replacement of the supports broker appointment or change of a personal representative, etc.) does not eliminate the problem, the participant will be informed in writing of the plan to transfer to traditional services. DLTC, in collaboration with the supports broker, will ensure that no break in vital services and a timely revision of the service plan occurs. The decision to involuntarily terminate is made by the supports broker, consumer support team and the participant. The participant may appeal this decision in writing to DLTC within thirty days of notification by the supports broker. Circumstances of involuntary termination will be described in a memorandum of agreement terms that the EPD waiver participant and the Vendor F/EA FMS/Supports Broker entity will be required to sign before the beginning services. If an EPD waiver participant violates the conditions of the agreement, their involvement in participant-direction may be terminated. Examples of actions to warrant involuntary termination may include a refusal to collaborate with the supports broker on ISP development, or a refusal to hire and appropriately manage qualified direct care workers. The EPD waiver participant will not be terminated from PD option until after appeal has been reviewed and denied. If appeal is upheld services continue without interruption. If a participant violates the participant directed memorandum of agreement terms and conditions and is involuntary terminated from participant direction, he/she can choose either no service or traditional EPD Waiver services.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		0
Year 2		10
Year 3		20
Year 4		30
Year 5		40

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☑ **Determine staff wages and benefits subject to State limits**
☑ **Schedule staff**
☑ **Orient and instruct staff in duties**
☑ **Supervise staff**
☑ **Evaluate staff performance**
☑ **Verify time worked by staff and approve time sheets**
☑ **Discharge staff (common law employer)**
☑ **Discharge staff from providing services (co-employer)**
☑ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The same assessment of needs used for traditional EPD waiver services will be used for PDS.
Provider payment rates are uniform for every provider of a waiver service.
• DHCF, the Medicaid Agency for the District of Columbia, solicits public comments through the District rule-making process, which provides for a 30 day public comment period.
• Information regarding payment rates are made available to the waiver participants via publication of the proposed and ratified rules, which is published and publically available.

The District's participant directed service (PDS) participant has the ability to self-direct a budget needed to hire staff and purchase approved services, supports and goods. The DHCF monitors the overall individual recipient budgets through monthly review of the Medicaid Management Information System (MMIS) claims information and detailed monthly reports from the FMS with the intent of maintaining cost neutrality and ensuring that money is allocated according to participant need, as outlined in each participant's service and support plan (plan of care/ISP). Each PDS participant, working with their Support Broker, FMS, and a support team of their choosing, assesses his/her needs, develop his/her goals based on needs, and develop an individual services and supports plan (plan of care/ISP) to meet his/her goals.

This plan of care may include both traditional and self-directed services. Once all of the participant's goals are addressed they are prioritized and the services the participant has selected to self-direct are priced-out into a spending plan. Each participant's monthly individual budget will be the monthly average of the sum of the

waiver services costs incurred by the participant during the previous Fiscal Year (beginning with FY 2013).If the participant was not in the EPD Waiver previously the person will receive the average EPD Waiver annual expenditure for one person for the prior year. Funds for supports broker, and Fiscal Management Services will be taken from each budget at the approved Medicaid rate of $275/ month for FMS; $250 initial and $175/month for supports broker; or $500 initial. The PDS participant's fiscal intermediary or FMS handles employer functions and pay providers for their services, based on the approved budget.

Each PDS participant should choose supports broker. For participants with fewer than 12 months expenditure experience prior to choosing PDS, the average monthly costs incurred for the number of full months of participation in the EPD waiver will be used. For new participants choosing PDS, who have no prior waiver cost experience, the initial monthly individual budget will be the mean of all participants of similar characteristics (e.g., diagnostic, age, gender, etc.).

The self-direct budget ceiling will not exceed the mean of total EPD Waiver services for the preceding year of the total budget for the waiver participant.

When the DHCF DLTC EPPDB approves the service and support plan, they authorize FMS and support broker to team with the recipient to begin services using an approved procurement process.

The self-direct budget amount is what the participant will use to direct all participant directed services and supports, as designated in his/her support and spending plan and any other self-direct services the participant elects to self-direct (refer to Appendix E-1:g for a list of self-direct service options). The FMS and supports broker assists the participant in managing his/her self-direct budget.

Participants have the authority to decide which services, goods or supports to purchase and how much money to pay for each item within the self-direct budget. A suggested range of rates for services is available from the FMS as a point of reference for the planning stages.

Participants will have the ability to save money within their self-direct budget during the fiscal year for larger one-time purchases. Savings may be used to purchase goods and services outlined in the service and support plan of care. Unused budget money will be pooled at the end of the year for participants to access for one-time purchases. Self-direct budget spending may not affect individual budget determinations for the following year.

Information about self-direct budget methodology will be made publicly available on the DHCF www.dhcf.dc.gov and the DCOA/ADRC www.dcoa.dc.gov websites.

PDS participants will have authority to expend PDS waiver funds for services through an approved monthly individual budget.

Once begun, each participant's paid claims file for Fiscal Year 2013 will be used to identify precisely the total cost of services incurred by each participant. All participants' individual budgets will be calculated using the same formula above.

As the District gains experience with actual service costs and utilization under the PDS approach, the District plans to refine the individual budget methodology during the next waiver cycle to reflect better the District's PDS experience.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

A supports broker from the Vendor F/EA FMS/Supports Brokerage entity reviews the participant-directed individual budget with the participant (and representative as necessary) during the initial phase of the assessment for services and thereafter with the participant/representative on a monthly basis. These monthly

meetings to review the participant-directed individual budget are held to inform and familiarize the participant/representative with the services and associated expenditures and to review all projected and utilized services and expenditures for the year. When an adjustment is needed in the participant's individual budget that exceeds the allocated amount for cost neutral services the request with actual justification is submitted to the Vendor F/EA FMS/Supports Brokerage entity. Denials for adjustments and/or budget increases or reductions can be submitted to DLTC. If a participant/representative chooses to appeal DLTC's decision (s) he/ she can file a formal appeal in writing with the Office of Administrative Hearings.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

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

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Changes are documented in the participant-directed individual budget justification and shared with the Vendor F/EA FMS staff and his/her supports broker. Services can be modified or changes made but must be consistent with the participant's ISP. If changes are inconsistent with the ISP, participants can request a modification to the ISP. The participant then will work with the supports broker to revise the ISP, and changes must be mutually agreed upon and approved by the Vendor F/EA FMS/Supports Broker entity and the participant/representative. Major changes that require significant budget modification that will exceed budgeted dollar amount as projected must be reviewed by Vendor F/EA FMS staff, supports broker and DLTC.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Each participant will be allotted a specific amount of money each year which they will be able to use to purchase pre-approved individual-directed goods and services from vendors and receive personal care from the qualified workers they hire directly. This annual allotment will comprise the participant-directed individual budget. The Vendor F/EA FMS/Supports Brokerage entity may not make payment for invoices for individual-directed goods or services unless the participant-directed individual budget has adequate funds to cover the costs and the purchased good or service is listed in the participant-directed individual budget. The supports broker will maintain a copy of the participant-directed individual budget, and is responsible for verifying that expenditure requests are within the participant's participant-directed individual budget within the flexibility of participant authority to modify his or her individual budget.

The Vendor F/EA FMS/Supports Brokerage entity will prepare and submit monthly participant-directed service utilization and expenditure reports to DLTC, and submit monthly statements of participant-directed service expenditures and balances to participants/representatives with a copy to their supports broker.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The beneficiary freedom of choice form specifies that the beneficiary has the right to choose to reside in an institutionalize setting or a home and community base setting. It is also documented in the form that the beneficiary has the right to choose which provider he/she selects to provide services to them. A list of current approved providers is given to the beneficiary or significant other to choose from.

All applicants /beneficiaries have a fair hearing entitlement. At the time of application for Medical Assistance each applicant/beneficiary will be informed, verbally and in writing, of the conditions under which he/she is entitled to request a fair hearing. In addition, applicants/beneficiaries are provided with the process for requesting such a hearing, the right to present witnesses, the right to be represented by legal counsel or other spokespersons of choice, the right to have reasonable expenses related to the hearing paid by the District of Columbia Government, and that legal services are available to the applicant/beneficiary.

Any applicant/beneficiary for Medical Assistance aggrieved by department action or inaction which affects his/her participation in a Medicaid program or level of benefits received may request a fair hearing. A hearing request is a clear expression, oral or written, by the applicant/beneficiary or his/her representative that:

- The applicant/beneficiary wishes to appeal a decision of DHCF.
- The applicant/beneficiary wants an opportunity to present his/her case to a higher authority.

The request for a hearing may be filed with any employee of DHCF or may be filed directly at the Office of the Health Care Ombudsman and Bill of Rights. The right to request a hearing may not be limited or restricted in any way. The request may be made verbally or in writing. DHCF must assist the applicant/beneficiary in completing his/her hearing request, when asked. Upon receiving a request for a fair hearing, DHCF representative shall complete a Hearing Request for Medicaid Programs and Health Care Alliance Form. A request for a fair hearing must always be accepted and should be electronically transmitted by facsimile to the Office of Fair Hearings (OFH) on the date it was received. The original copy of the fair hearing request and the customer's case record should be forwarded to OFH within 48 hours.

All applicants/beneficiaries shall be afforded the right to request a hearing on any action taken by the agency, including loss of benefits, which occurred in the prior 90 days. All applicants/recipients shall also be afforded the right to request a hearing to appeal a denial of a request for restoration of benefits lost more than 90 days ago but less than one year prior to the request. All applicants will be afforded the right to request a hearing if they are not notified of a decision on their application within the time allowed. In addition, at any time during the certification period, a beneficiary may request a fair hearing to dispute his current level of benefit.

All applicants/beneficiaries may request and is entitled to receive a postponement of a scheduled hearing.

Under certain circumstances, if an applicant/beneficiary requests a fair hearing within specified time frames; adverse actions cannot become effective pending the outcome of the appeal. DHCF shall not permit the adverse action to become effective if the following criteria are met:

The recipient requests the fair hearing before the effective date of the adverse action or within 15 days of the postmark date on the notice of adverse action and/or whichever is later. Medical assistance shall be continued at the previous level unless the recipient specifically waives continuation of Medical assistance. DHCF shall implement the adverse action, only if a recipient requests in writing that the adverse action be allowed to take effect pending the outcome of the appeal.

A record of the hearing and recommendations for final decision will be provided to the Director of the Department by the hearing officer. All the recommendations of the hearing officer will comply with federal law and regulations and will be based on the record. The hearing officer's written findings, conclusions, and recommendations will be transmitted to the

applicant/beneficiary or the representative with an explanation that the decision or determination has been submitted simultaneously to DHCF. The package sent to the applicant/beneficiary will explain that the decision of the fair hearing officer is a recommendation and does not constitute the final decision of DHCF.

If the hearing officer recommends that the action of the department be sustained, the applicant/beneficiary will be notified that he has 10 days to present newly discovered evidence for review by the hearing officer.

The OFH will monitor implementation of all final decisions. The Administrator for DHCF will implement all final hearing decisions.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

The Department of Health Care Finance (DHCF)' Division of Long Term Care, Elderly Persons with Physical Disabilities Branch (EPPDB) is responsible for the operation of the grievance/complaint system. Additionally, the District of Columbia Office of the Health Care Ombudsman and Bill of Rights (OHCOBR), an independent office located in the District of Columbia DHCF operates a separate complaint resolution system, to which waiver participants may also make complaints. DHCF's Health Care Division Management Administration (HCDMA) that includes the Division of Long Term Care (DLTC) have standing bi-weekly meetings with OHCOBR to coordinate on the resolution of all types of complaints including those pertaining to all of long term care including those related to this waiver, and to facilitate the development of program improvements to address underlying systemic issues that may have lead to the complaint.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) Participants may make all types of complaints or grievances to EPPDB pertaining to the denial or provision of waiver services. These include, but are not limited to, complaints about: denial or reductions of service; the process or results of their waiver eligibility determination; poor timeliness or quality of care; restriction of their rights; lack of or

interference with choice of provider; issues related to the waiver waiting list; patient abuse, neglect, or exploitation by waiver providers; and violations of patient privacy or confidentiality. All complaints about abuse, neglect, or exploitation by waiver providers will follow the EPD Waiver Incident Management process.

(b) The timelines for resolving complaints are as follows. All complaints that indicate that a beneficiary's health and/or welfare are at immediate risk are addressed within 24 – 48 business hours of receipt. Complaints pertaining to Medicaid eligibility determination and denial or reduction of service are addressed within five (5) – ten (10) business days; all other complaints are addressed within ten business days and resolved within thirty (30) days of the receipt of the complaint. If the complaint remains unresolved after the third week, it is forwarded to Project Manager of the EPPDB for his/ her intervention. If after thirty (30) days the complaint remains unresolved, it is forwarded to the Project Manager for the Division of Long-Term care for his/ her intervention. Complainants are also informed upon the initiation of the complaint of the right to a fair hearing and how to obtain one.

(c) When a beneficiary or advocate authorized by the beneficiary contacts the EPDB, the complaint is documented and logged into Complaints Log system and assigned to one of several staff persons in EPDB for investigation and resolution. These staff investigate and use a variety of processes and mechanisms to resolve the complaint, depending upon the nature of the complaint. These processes and mechanisms include, but are not limited to: interviewing the beneficiary, beneficiary representative, service provider, and others with knowledge of the problem to obtain a clear understanding of the problem; reviewing the beneficiary's service records and provider documentation; and reviewing billing records. Once the problem is well understood, staff can take a number of actions as appropriate including: directing the provider to develop (to be approved by staff in the EPDB) and implement a corrective action; assisting the beneficiary to choose another provider and transfer to that provider; referring the situation to Adult Protective Services; referring the situation to the DHCF Division of Program Integrity when instances of provider fraud or abuse are suspected; and referring complainants to the fair hearing process when certain complaints are not addressed to their satisfaction or involve issues pertaining to eligibility for or denial of services. EPDB informs all complainants that filing a grievance or complaint is not a prerequisite for a fair hearing, and informs the complainant of his or her right to request a "fair hearing if: the request for Medicaid eligibility is denied or not acted upon promptly; Medicaid eligibility is terminated or suspended; or the complainant believes a request for a service has been wrongfully denied, reduced, or not acted upon promptly.

The OHCOBR is comprised of two legislative requirements, the Ombudsman's Program (D.C. Code § 7-2071.01) and the Grievance Procedures for Health Benefit Plans (D.C. Code § 44-301). In February, 2008, the D.C. Medical Assistance Administration of the D.C. Department of Health (DOH) became a separate, cabinet-level agency, DHCF, for the administration of the Medicaid program (D.C. Code § 7-771) and obtained jurisdiction over matters pertaining to both requirements. These laws, regulations, and policies pertaining to complaints and grievances are available to CMS upon request.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The District recognizes two categories of incidents: serious reportable and reportable incidents. A Serious Reportable Incident (SRI) is a significant event or situation which due to its severity requires immediate response, notification to, and internal review and investigation by the provider agency and/or the DHCF. SRIs include, but are not limited to: death; abuse; neglect; exploitation; theft of consumer personal property; serious physical injury; inappropriate or unauthorized use of restraints; suicide attempt; and serious medication error. A Reportable Incident (RI) is a significant event or situation involving a participant and shall be reported to the DHCF, and investigated by the provider. RIs include, but are not limited to: medication error; missing person; hospitalization; suicide threat; vehicle accident; fire; police; emergency room visit; emergency relocation; property destruction; and, other events or situations that involve harm or risk of harm to a participant.

All employees, sub-contractors, consultants, volunteers or interns of a Elderly Persons with Disability (EPD) provider agency or government agency are required to notify the DHCF within 24 hours or the next business day, of occurrence, when a serious reportable incident or reportable incident is witnessed, discovered or becomes know. Notifications are made via facsimile or reported electronically through the DHCF's Casenet system. Casenet is the DHCF's case management tracking system. All case management providers are required to electronically report incidents.

In the event of a serious reportable or reportable incident the provider is required to document the incident on its internal incident report form and complete an internal investigation within five business days of the incident's occurrence. Furthermore, the provider is required to submit all incident report forms to the DHCF.

Additionally, for all serious reportable incidents involving death, neglect, abuse and theft of consumer personal property, occurring at a participant (s) natural home the provider is required to report the incident to the DHCF and the District of Columbia, Adult Protective Services (APS). Deaths that are expected and/or of natural causes are not required to be reported to APS.

With the exception of case management agencies, for all serious reportable and reportable incidents the provider is required to report the incident to the DHCF and the District of Columbia, Department of Health/Health Regulation and Licensing Administration (DOH/HRLA). Case management agencies are not licensed by DOH/HRLA, therefore, are not required to report incidents to that entity. Further, all serious incidents involving death or criminal activity which occurs at an assisted living facility are reported by the provider to the District of Columbia, Metropolitan Police Department (MPD). These incidents include, but are not limited to abuse or theft of consumer property.

Incident data reported to the DHCF is entered and tracked on an internal complaint log maintained by staff in the DHCF's Elderly Persons with Physical Disabilities Branch (EPPDB) and aggregated by the DHCF's, Division of Quality and Health Outcomes (DQHO) for trends. Additionally, DQHO generates quarterly and ad hoc quality reports on incident management data as part of the District's quality improvement efforts.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Training and information are offered to participants and or families or legal representatives in the following manner: All participants and their family members/legal representatives are provided with information about the EPD Waiver including the protections and safeguards that are afforded them.

The District is formulating an incident management policy that will recommend to the EPD waiver providers best practices to follow in the area of incident reporting and investigating, to include how to identify and report abuse, neglect and exploitation. Providers shall develop an internal protocol to ensure compliance with this policy. The protocol shall establish procedures, to include the responsibilities of employees, interns, volunteers, consultants and contractors with regard to identifying, reporting, investigating, addressing and monitoring the follow-up of incidents.

On an annual basis, EPD waiver providers are required to train and educate participants regarding abuse, neglect, mistreatment and exploitation, and as part of enhanced quality expectations are expected to use naturally occurring opportunities throughout the year to reinforce the learning process.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Incident Management refers to the reporting and prevention of abuse, neglect, and exploitation of participants served

in Medicaid-funded, home and community-based service programs. Incident Management also includes the reporting of participant involvement with law enforcement or emergency services; the reporting of environmental hazards that compromise the health and safety of a participant; and reporting the death of a participant.

The DHCF's EPPDB ensures that all incidents submitted by the provider are adequately completed within 24 hours or the next business day, of the incident being reported to the DHCF. When necessary, the designated staff in the EPPDB contacts the provider to ensure that required notifications were made. The designated staff also verifies that all serious reportable incidents involving allegations of abuse, neglect, exploitation and theft of consumer personal property, where staff was alleged to be involved in the incident have been removed from contact with the participant until receipt by the DHCF of a satisfactory investigation from the provider.

All serious reportable incidents are investigated by the provider, submitted to the DHCF and reviewed by the DHCF's EPPDB to determine the need for additional follow up/remediation, or the need for an investigation by the EPPDB. Reportable incidents are written on an incident report form, investigated by the provider and the investigation report is maintained on the provider site and made available to all pertinent DHCF employees.

Follow up/ remediation action requested by the DHCF in response to an investigation is to be implemented within ten business days of receipt of notice from the DHCF. Any follow up/remediation action not addressed by the provider after receiving notice must be supported and acceptable by the DHCF. Further, when a provider fails to address follow up/remediation action the DHCF will recommend that the involved participant selects an alternate provider. Additional remediation action may be initiated by DOH/HRLA.

The provider may report the outcome of an investigation to the participant. Timeframes for informing the participant of the investigation results are done within one business day of completion of an investigation.

Timeframes for reporting an incident can be changed or adjusted when there are health and safety concerns that require immediate response.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

On a quarterly basis, the EPPDB submits its complaint log and other incident management data to the DQHO who conducts an analysis of data collected as part of the incident management process. The DQHO evaluates trends of incident data and present findings to EPPDB for needed follow up with the provider.

Quarterly reports of incident management trends and findings are prepared for dissemination and review by the District's steering committee which has responsibility for monitoring performance of all EPD waiver providers.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The District of Columbia Assisted Living Residence Regulatory Act of 2000 (ALR) prohibits the use of restraints and restrictive interventions in Assisted Living Facilities. In addition, ALR also references the sanctions and remedies which are outlined in the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983. The Department of Health Regulatory Licensing Agency (DOH HRLA) monitors Assisted Living facilities for use of restraints and/or other restrictive interventions. Oversight is conducted via routine annual surveys, surveys triggered by complaints or incidents, and more frequently when deficient practices are detected, as stipulated in the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983. Interviews also occur with patients, family, direct care staff,

health care delivery teams. Reviews are conducted more frequently based on severity and frequency of complaints.

Any detected violations of the prohibition on use of restraints and restrictive interventions in Assisted Living Facilities are reported to the state Medicaid agency. Although this occurs at present via informal procedures, as part of implementing this waiver the state Agency will formalize these processes through a Memorandum of Understanding with DOH. This MOU will specify that HRLA will supply DHCF with the reports which contain details about deficiencies, and the imposition of any sanctions consistent with District statutory and regulatory authority. The MOU will be executed by March 30, 20

- **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.
  - **i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
  - **ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

- **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Health Health Regulatory Licensing Agency (DOH HRLA) is responsible for the monitoring of unauthorized use of restraints and/or seclusion on an annual basis, at a minimum.

- **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.
  - **i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.
  - **ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The State does not permit or prohibits the use of seclusion

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable *(do not complete the remaining items)*

Yes. This Appendix applies *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and

oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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

- **Not applicable.** *(do not complete the remaining items)*
- **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

- **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the State:

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of beneficiaries critical incidents reported within forty eight (48) hours. N:# of beneficiaries critical incidents reported within 48 hours; D:# of all critical incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Casenet

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =

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

Data Aggregation and Analysis:

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

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

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

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

☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Casenet

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

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

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

Performance Measure:
Number and percentage of beneficiaries who received care within the Personal Care Aide's (PCA) scope of practice. N:# of beneficiaries who received care within the PCA's scope of practice, D:# of records reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%, 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

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

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

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

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

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

The District uses a variety of mechanisms to monitor the health and welfare of waiver participants, including a complaint database and a DLTC Monitoring Unit that serves as a point of contact for identifying complaints and incidents and initiating appropriate actions in response to such complaints and incidents. Specifically, when an incident is reported to the DLTC Monitoring Unit by a provider, beneficiary or another entity, the unit contacts the beneficiary's provider and initiates one of the following activities: refers the incident to the Adult Protective Services (APS), refers the incident to another appropriate agency or begins a corrective action immediately. The process to address the complaint begins with a combination of the following: an announced or unannounced visit to the provider agency and/or beneficiary's home or a conference call between all parties to discuss the complaint. Also, the DLTC Monitoring Unit will review clinical records, personnel files, complaint/incident binders, etc. to obtain additional, relevant information. DLTC staff will recommend that the provider, in conjunction with the beneficiary, develop or revise a plan to prevent similar incidents from occurring in the future.

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

As potential system improvements, the District also suggests collaborating with HRLA staff who conduct home visits within the EPD Waiver program and recruiting student intern volunteers from local nursing and social work academic programs to conduct participant experience and satisfaction surveys.

b. Methods for Remediation/Fixing Individual Problems

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

The DLTC EPD has monitoring staff who conduct a review of the provider from which the complaint originated and subsequently triages complaints to identify and investigate the nature of the complaint and refers it to the appropriate regulatory agency. Specifically, if a complaint occurred within a specific provider agency and that agency did not initiate an internal timely investigation, then DHCF's DLTC monitoring unit would send the provider agency a deficiency report and refer it to the appropriate agency for follow-up, ie. Program Integrity, HRLA, Adult Protective Services, etc.

When DHCF detects problems in Health and Welfare, it has several sequential strategies it will use to address them. These include:

1) Meeting with providers (individually or as a group) to deliver education to correct the detected problems. This will most often be used for a first-time occurrence of a problem of a specific type. Meetings will be conducted by staff from DHCF's Elders and Persons with Physical Disabilities Branch. If a problem is detected across multiple providers, DHCF will send an official written transmittal to all providers describing the problem and how DHCF requires it to be addressed. Documentation of these efforts will be made by DHCF's Elders and Persons with Physical Disabilities Branch as notes on individual providers, notes on the agenda of monthly provider meetings, or as copies of the transmittals.

2) Problems that recur will be addressed through additional training and the delivery of a written notice from DHCF requiring the correction of the problem. DHCF's EPD is responsible for documenting the remediation process with individual providers and retains documentation.

3) Problems that persist will be addressed through more stringent means including the recoupment of Medicaid payments associated with claims related to the service plan problem. Such recoupments are handled by DHCF's Office of Utilization Management which maintains records of all such recoupments.

4) Serious and /or repeated violation of standards for service planning can result in termination of the provider

in accord with DHCF's Administrative regulations. Provider terminations are handled by DHCF's Office of Program Integrity which maintains documentation of all such provider actions.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term

care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the* QIS and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Quality Strategy is as follows. For practices yet to be finalized, specific tasks to be undertaken during the waiver period, major milestones, & identification of the entity responsible for completing tasks are specified.

YEAR ONE: The process used to establish priorities & strategies for, & implement system improvements for year 1 of the waiver are derived from internal State agency review of waiver operational practices; complaints from beneficiaries, the DC Health Care Ombudsman, & external advocacy organizations; & evaluation of the closely related state plan personal care aide (PCA) benefit.

Review of waiver activities by the new Agency management identified priorities for systems improvement: better measurement of system performance; creation of written policies & procedures; reduce delays in waiver application determinations; timely redeterminations, coordination between state plan & waiver PCA services; & evaluation & remediation of over, under, & mis-utilization of waiver services. Quality improvement (QI) activities under the prior waiver predominantly have occurred on a beneficiary-by-beneficiary, problem-by-problem basis, as opposed to QI activities at the system level.

As a result, priority for the 1st yr of the waiver is to ensure that each waiver assurance is met by:

1 implementing stronger measurement of system performance & follow-up activities for each assurance;
2 writing policies & procedures for waiver activities & training those responsible for implementation;
3 improving waiver application process for beneficiaries;
4 ensuring timely redeterminations;
5 implementing ongoing, valid & reliable processes to measure & remedy over, under, & mis-utilization of waiver services;
6 coordinating PCA service under the waiver with the state plan PCA benefit.

Parties measuring performance & making improvements, & roles & responsibilities are:

Manager, Division of Long Term Care (M, DLT)

1 direct development & documentation of policies & procedures for waiver activities & training those responsible for their implementation;
2 develop & implement approaches to improving the waiver application process;
3 develop & implement an approach to ensure timely redeterminations;
4 develop & implement policies & procedures to coordinate waiver PCA services with the state plan PCA benefit.

Manager, Division of Quality & Health Outcomes (M, DQHO)

develop & implement

1 measurement of delivery system performance, including performance measures for all waiver assurances;
2 ongoing, valid reliable processes to measure & remedy over, under, & mis-utilization of services.

Management Analyst, Division of Quality & Health Outcomes

1 measure delivery system performance using established performance measures & report results to Manager, Division of Long Term Care
2 measure utilization of services to detect over, under, & mis-utilization of waiver services & recommend strategies for remediation.

District of Columbia Long Term Care Coalition

1 reviews measure of delivery system performance & beneficiary experiences with care & suggests strategies for improvement
3 oversees strategies for improving waiver application process, & provides feedback on effectiveness;
4. oversee strategies for ensuring timely redeterminations & provides feedback on effectiveness;

Program Staff, Division of Long Term Care, Elders & Persons with Disabilities Branch

1 implement policies & procedures for waiver implementation;
2 monitor waiver application process; &
3 monitor timeliness of redeterminations.

Tasks to be undertaken during waiver, major milestones for each task, & entity responsible for completing each task are:

TASK 1 Implement stronger measurement of delivery system performance & follow-up activities for each waiver assurance

The District will use the performance measures specified in Appendices A though D to assess compliance with each waiver assurance.. However, additional measures may be needed. Further, the process whereby these measures will be deployed needs to be formalized & embedded into routine operations.

Responsible entity: M, DQHO

Milestones

Review all performance measures specified in the waiver to ensure they adequately & appropriately address all waiver assurances 12/30/11

Develop new measures & their specifications as needed; 12/30/12
Develop a table format showing performance measures to be used, entity responsible for calculating the measure according to specifications, the receiver of the performance measure, & the entity responsible for taking follow up action on the measures, as appropriate. 2/15/12
Implement performance measurement & remediation 3/15/12
Monitor production & use of performance measures to achieve change Begin 3/15/12 & ongoing.

TASK 2 Write policies & procedures for waiver activities & train those responsible for their implementation

Responsible entity: M, DLT

Milestones

Develop a list of all policies & procedures needed to guide waiver operations & fulfill each assurance. Such policies & procedures will include, but not be limited to: processing applications for waiver participation by elderly persons & persons with disabilities, processing applications from potential providers, prior authorization of waiver services, conducting monitoring site visits, performing case management responsibilities, achieving timely waiver participation redeterminations, & implementing & maintaining a waiting list for waiver services. 12/30/12
Write needed policies & procedures 12/3-/11 – 3/30/12
Obtain Agency sign–off on policies & procedures 4/15/12
Train responsible staff in policies & procedures 4/30/12 & ongoing
Implement & monitor waiver activities in accord with policies & procedures 5/1/12 & ongoing

TASK 3 Improve the waiver application process.

Responsible entity: M, DLT

Milestones This will be undertaken in conjunction with developing policies & procedures for processing applications for waiver participation by elderly persons & persons with disabilities, discussed in TASK 2, above. Work on this is already underway.

Document the current process for processing applications for waiver participation 12/31/11.
Identify recommended approaches to streamline this process & make it more timely & reliable. 1/30/12
Implement adopted strategies (The date of this milestone is less certain. It will depend on the nature of the action(s) to be adopted. However, we propose the following milestone as a checkpoint: 7/30/12
Write policies & procedures 8/30/12
Obtain Agency sign–off on policies & procedures 9/30/12
Train responsible staff in policies & procedures & implement 9/30/12 & ongoing

TASK 4 Ensuring timely redeterminations

Responsible entity: M, DLT

Milestones This will be undertaken in conjunction with developing the policies & procedures for waiver eligibility re-determinations in TASK 2, above.

Document the current process for waiver eligibility redeterminations 12/30/11.
Identify recommended approaches to streamline this process & make it more timely & reliable. 1/30/12
Implement adopted strategies (The date of this milestone is less certain. It will depend on the nature of the action to be adopted. However, we propose the following milestone as a checkpoint): 7/30/12
Write needed policies & procedures 8/30/12
Obtain Agency sign–off on policies & procedures 9/30/12
Train responsible staff in policies & procedures & implement 10/15/12 & ongoing

TASK 5 Implementing ongoing, valid & reliable processes to measure & remedy over, under, & mis-utilization of waiver services

Creating & implementing ongoing, valid & reliable processes to measure & remedy over, under, & mis-utilization of waiver services is a substantial undertaking that will involve participation & coordination of multiple State Agency Administrative units including the: division of Program Integrity's Surveillance & Utilization Branch, Division of Research Analysis & Rate Setting, Division of Quality & Health Outcomes, & the Health Care Delivery Management Administration's Division of Long Term Care's Elders & Persons with Physical Disabilities Branch.

Responsible entity: M, DQHO

Milestones

Create & convene ad hoc committee (including but not limited to the entities described above) to develop strategy for detecting over, under, & mis-utilization of waiver services: 4/1/12
Ad hoc committee develops comprehensive, coordinated monitoring plan. The Monitoring Plan will identify data to be collected & analyzed, sources of the data, entities responsible for collecting & analyzing the data to generate reliable & valid information on utilization, frequency of data collection & analysis, & the entities responsible for taking remedial action as needed. 9/30/12
Implementation of processes for detection & remediation of over, under, & mis-utilization: 4/1/12 & ongoing.

TASK 6 Coordinate PCA services under the waiver with state plan PCA benefit.

Both the state plan & this waiver offer personal care aide (PCA) services. Analysis of these benefits by the new management team has detected that this can sometimes result in two different agencies delivering personal care aide services, separate prior authorization requests by the two different agencies, & care plans that are not always coordinated. Further, the state plan benefit has recently implemented a number of reforms to ensure more appropriate use & higher quality of PCA services, & more are planned for FY12. The delivery of PCA waiver services will be improved by the coordination of these two benefits & delivery reform initiatives.

Responsible entity: M, DLT

Milestones:

Analysis of the array of potential reforms to better coordinate state plan & waiver PCA benefits. Potential reforms include but are not limited to: 1) when a waiver enrollee is receiving PCA services both through the waiver & the state plan, require that the PCA provider be one & the same for both state plan & waiver services; 2) implement as improved waiver processes the use of the new Physician order form, assessment instrument & care plan forms recently adopted for the state plan PCA benefit; 3) use a separate entity to perform assessment & care plan development to avoid potential conflicts of interest that might occur when the entity developing the care plan is the entity that will be delivering the services. 1/30/12

From the analysis, identify the specific reforms to be implemented 2/15/12

Complete a work plan for implementing the identified reforms, including the production of any needed regulatory changes or modifications of the waiver. 3/15/12.

Adoption of all items contained in the work plan – Timelines will vary according to each reform item.

TASK 7 Develop & Implement Continuous Quality Improvement Strategy (CQIS) for Waiver Year 2 & beyond.

The above tasks will occur in Waiver Year 1 & will address changes already identified by the team responsible for successful waiver implementation. Beyond these immediate issues to be addressed in waiver year 1, a CQIS for Waiver Yrs 2 & beyond will be developed & implemented.

Responsible entity: M, DQHO

Milestones

Create & convene ad hoc committee to develop CQIS beginning in years 2 & beyond: 6/30/12
Monthly meetings of ad hoc committee to develop ongoing plan specifying: how participants, advocates, &

others will participate in the CQIS; processes to assess effectiveness of the waiver & system improvements; measures & processes employed for remediation; how areas for improvement will be identified & prioritized; processes & timelines for compiling information & communicating to external parties; & processes to assess & revise QIS as needed. 9/30/12

Train parties responsible for implementing the CQIS 10/1/12 – 12/31/12

Implementation of the CQIS for yrs 2 & beyond 1/1/13

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Billing and Claims:
The effectiveness of any system change is measured by assessing whether the changes truly function as designed and whether the design produced the anticipated results. HCOA is responsible for ensuring that changes made to the MMIS are in line with the agreed upon design. Once a change is implemented in production ACS monitors the change and captures three instances where the change worked as designed. A CSR can only be closed once the proof in production requirement has been satisfied.

In order to assess whether the design is producing the anticipated results, reports are often created that allow program staff to monitor progress. Reports can be created on an ad hoc basis or put into production as a standard daily, weekly, monthly, quarterly or annual report. All standard reports are placed in a web based reports repository called Reports On Line (ROL) that is accessible via the secure portion of the DHCF web portal. DHCF employees are provided access to the secure portion of the web portal via user names and passwords.

In addition to canned reports certain DHCF staff members have access to a Cognos database that can be used to access data directly and generate custom reports in real time. HCOA works closely with program staff to ensure that the database contains the data elements needed to perform proper analysis and that data is being interpreted correctly.

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

Appendix H: Quality Improvement Strategy

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

Task 1. Convene and charge DHCF Team responsible for Quality Improvement Activities. DHCF underwent a second realignment in June of 2011 (the first occurred in October of 2010), which, among other things, moved

the former Office of Quality Management into the Health Care Delivery Management Administration, in which the Division of Long Term Care and its Elders and Persons with Disabilities Branch (EPDB) are located. This move was undertaken to more closely integrate quality improvement activities and a focus on health outcomes into the delivery of Medicaid services.

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

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

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

Although this full strategy will not be in place until January 2012, below are the task that will be undertaken in the next three months to fully develop and implement DHCF's strategy for Continuous Quality Improvement of service delivery via this waiver. The completion of these task will be directed by DHCF's Director of HCDMA and Manager of the Division of Quality and Health Outcomes, who together have substantial experience and expertise in health care quality measurement and improvement in general, and for the Medicaid program, in particular.

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

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

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

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

need be planned to be used for different assurances.

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

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

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Financial integrity is promoted through pre- and-post payment processes. Pre-payment activities are described in section I- 2-d Billing Validation Process.

The State Agency is required to perform post payment audits under Chapter 42 of Title 29, DC Municipal Regulations (29 DCMR § 4236). To fulfill this requirement, a random sample of claims for selected waiver services is annually audited by the State Agency's Division of Program Integrity - Surveillance and Utilization Branch. These audits consist of visits to waiver providers' offices to compare information submitted on the claims to patient care documentation and assess whether or not the services billed for are: included in the participant's approved service plan, were provided, and meet other requirements of the waiver. In instances in which claims appear to be unsubstantiated the state agency begins a recoupment process and returns the federal share, when recoupment is upheld through reconsideration and appeals processes, consistent with federal regulations. Random sampling of such claims is an efficient approach to validation and ensuring appropriate payment recovery because the rate of denied claims in the sample can be applied to the universe of similar claims from the provider and a percent of payment equal to the error rate observed in the sample can be recovered.

In addition, the District of Columbia Office of the Inspector General conducts audits, as indicated.

Finally, every year, the entire Medicaid grant, including the portions funding the EPD Waiver, is audited as part of the Single Audit of all the federal grants awarded to the District. The Office of Integrity and Oversight within the Office of the Chief Financial Officer (of the District) oversees the Single Audit. In FFY 2010, KPMG conducted the Single Audit.

4236 AUDITS AND REVIEWS

4236.1 The MAA shall perform ongoing audits to ensure that the provider's services for which Medicaid payments

are made are consistent with efficiency, economy, quality of care, and made in accordance with federal and District rules governing Medicaid.

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

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

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

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

4236.6 The recoupment amounts for denied claims shall be determined by the following formula: A fraction will be calculated with the numerator consisting of the number of denied paid claims resulting from the audited sample. The denominator shall be the total number of paid claims from the audit sample. This fraction will be multiplied by the total dollars paid by MAA to the provider during the audit period to determine the amount recouped. For example, if a provider received Medicaid reimbursement of ten thousand dollars ($10,000) during the audit period, and during a review of the claims from the audited sample, it was determined that ten (10) claims out of one hundred (100) claims are denied, then ten percent (10%) of the amount reimbursed by Medicaid during the audit period, or one thousand dollars ($1000), would be recouped.

4236.7 The MAA shall issue a Notice of Recoupment (NR), which sets forth the reasons for the recoupment, including the specific reference to the particular sections of the statute, rules, or Provider agreement, the amount to be recouped, and the procedures for requesting an administrative review.

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

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver service claims reviewed that were submitted for participants who were enrolled in the waiver on the date that the service was delivered. N:# of waiver service claims reviewed D:# of waiver service claims submitted.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☐ **Annually**

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Convenience sample of 30 claims chosen at random using automated random selection program (e.g., RATSTAT or MMIS-adjunct software).
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
In addition, scheduled reporting to CMS using 372 cost neutrality formulas provides opportunites for review, analysis, detection, and refinement.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Problems related to financial accountability are addressed in three ways: by focusing on the MMIS and creating payment rule edits, by focusing on providers, and by focusing on program integrity as part of provider post payment audits and reviews. All these methods can and often do occur concurrently with appropriate communication among all parties involved as independent units within the agency
.

The first method is to focus on MMIS payment rules:
As part of its responsibilities, the District's fiscal agent maintains systems staff and contractors who develop, maintenance, and produce automated financial reports. The reports include both federally mandated reports (including the 372 waiver reports) and specialized financial oversight reports requested by the Office of the Chief Financial Officer (OCFO). If there are any suspected issues with any aspect of financial reporting, the OCFO, waiver program staff, and the fiscal intermediary meets to discuss the issues and identify solutions. In addition, as a general part of root cause analysis, ad hoc reports are frequently generated and reviewed. Any issues related to financial reporting and this waiver are considered "open" until approval is obtained from the OCFO. If a system change or change to a production report is required to remedy an issue, the formal process for requesting changes to the MMIS system is adhered to. When the issue is resolved, emails are exchanged documenting formal decisions made and capturing any data used to come to those decisions.

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

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

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

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

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

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

◉ **No**

○ **Yes**

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

Appendix I: Financial Accountability

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

a. Rate Determination Methods. In 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).

The following principles apply to provider payment rates development for waiver services:

• Provider payment rates are uniform for every provider of a waiver service.
• DHCF, the Medicaid Agency for the District of Columbia, solicits public comments through the District rule-making process, which provides for a 30 day public comment period.
• Information regarding payment rates are made available to the waiver participants via publication of the proposed and ratified rules, which is published and publically available.

DHCF is responsible for all rate development with the assistance of program staff from the Division of Long Term Care / Elders and Persons with Physical Disabilities Branch (EPDB). Together, these DHCF units develop rates for each EPD waiver service. The rate information is available to participants upon request and is available on DHCF website at http://dhcf.dc.gov. 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 Long Term Care Coalition to discuss rates and rate structure as rates for direct care workers (Personal Care Aide (PCA)and Home Health Aide (HHA)
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 DHCF website.
7. Transmittal Letters from DHCF 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 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.

Personal care aides who work within the Waiver are paid on an hourly basis at a rate of $16.30. The prior 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. DHCF saw this as a quality of care issue. Added to this, District legislators moved to impose District living wage legislation. There is not a set methodology for determining rate increases. Rates are increased when DHCF 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, DHCF increased the rate from $13.50/hour to $16.30/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.
With respect to Participant Directed Services, rate setting methodology used to establish rates of payment for traditional Medicaid services will remain the same as described in the original waiver and will not apply to EPD waiver participants who choose to participant-direct. The Vendor F/EA FMS-Supports Broker entity's rates as described below will depend on the entity's rate proposals the bidders submit during the RFP contractor selection process.

EPD waiver participants who choose to direct their services will work with the Vendor F/EAFMS/Supports Brokerage entity to manage participant-directed services included in their participant-directed individual budget. The Vendor F/EAFMS/Supports Brokerage entity will receive a per-member-per-day payment to cover FMS and Supports Brokerage services. The payment rate will be comprised of one rate for Vendor F/EA FMS, and one or more rates for Supports Brokerage (information/assistance/counseling) services. The Vendor F/EA FMS/Supports Brokerage entity also may receive one-time payments for special projects as approved by DHCF, such as developing enrollment packets for beneficiaries prior to implementation. The fees, which will be determined by DHCF after Vendor F/EA FMS/Supports Brokerage entities competitively bid for the Vendor F/EA FMS/Supports Brokerage contract(s), will be subtracted from the beneficiaries' participant-directed individual budget. The EPD waiver participants will work with their supports brokers to establish wage rates for qualified direct care workers they hire directly and the charge to be paid for individual-directed goods and services identified for purchase.

The method for excluding the cost of room and board furnished in residential settings is as follows:
The service rate for Assisted Living was based upon a geographic market analysis that included a Technical Assistance Group and meetings with a cross section of Assisted Living Service Providers, large, medium and small and meetings with advocates, community leaders, national and local experts, including dialogue with Robert L. Mollica, Senior Program Director for the National Academy of State Health Policy. These meetings led to recommendations based on costs and review of service providers across the District of Columbia, Suburban Maryland and Northern Virginia. The TAG Group and DHCF examined the average daily rate for all inclusive costs among the small and medium sized Group Homes that might be interested in providing Assisted Living for District Medicaid residents either because they were already taking care of SSI and SSA participant or Nursing Facilities or other facilities that were considering taking on Medicaid Assisted Living participant. The TAG asked for a review of current costs among the small group home providers for services that they were providing or believed were needed. We asked for information on what were reasonable and customary services and how much did they pay for those services and how often were they used or offered, daily and weekly. The average weekly costs were then multiplied by fifty two weeks and then divided by number of persons receiving those services. This number was shared with the TAG who then reviewed their figures against those developed by DHCF. It was explained to the TAG group that Medicaid would not pay for Room or Board, only health care related services. The percentage of room and board costs were between 50 and 60 percent of total Assisted Living expenditures. This percentage was subtracted from the overall rate leaving costs that were on average $22,000 annually. This $22,000 cost was then divided by 365 days leaving an average cost of $60 a day. The $22,000 was compared to several facilities and was less than half as expensive as other Assisted Living facilities in the region. This was compared to the estimated number of persons that might be interested in Assisted Living and to geographic differences and provider supply. There was no automatic inflation increase and there is no set methodology for determining rate increases. It is anticipated that Assisted Living rates will be adjusted periodically to ensure adequate provider supply.
4238.1 The reimbursement rate for assisted living services shall be sixty dollars ($60.00) per day.
4238.2 The rate is an all-inclusive rate for all services provided. A provider shall not bill for individual services.
A. By adding section 4239 (Specific Provider Requirements: Assisted Living Services) to read as follows:
4239 SPECIFIC PROVIDER REQUIREMENTS: ASSISTED LIVING SERVICES
4239.1 Each facility providing assisted living services shall be licensed by the District of Columbia and comply with the requirements set forth in the Assisted Living Residence Regulatory Act of 2000, effective June 24, 2000 (D.C. Law 13-127; D.C. Official Code § 44-101.01 et seq.) and attendant rules.
4239.2 Each assisted living residence shall support the resident's dignity, privacy, independence, individuality, freedom of choice, decision making, spirituality and involvement of family and friends.

Providers may not bill for room or board or non-therapeutic health related services not identified in 4240.1.
4240.1 Assisted living services may consist of any combination of the
Services which meet the resident's needs as outlined in the written individualized service plan required pursuant to section 4202 of the District's EPD rules. Services may include the following:
(a) Personal care aide services;
(b) Chore Aide;
(c) Therapeutic social and recreational services

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All fee for service claims including those for waiver services are submitted to the Fiscal Intermediary, currently ACS Government Healthcare Solutions, for processing in the MMIS. Claims can be submitted on paper or electronically via HIPAA compliant transactions. Providers can submit electronic claims via the DHCF web portal, using billing agents or directly through third party software.

Once submitted, claims are processed through the MMIS and run through a large set of edits to ensure proper format and compliance with Federal and District regulations. Edits ensure that beneficiary's are eligible to receive the services rendered, providers are eligible to provide those services and that services were rendered appropriately. Claims that fail an edit can either deny or suspend for further review. Suspended claims are reviewed by ACS claims staff and are set to either pay or deny based on District rules and regulations.

Remittance Advices (RA) are produced and distributed to providers after every payment cycle identifying all claims processed their disposition (Paid/Denied/Suspended) and the total amount due to them. Any claims that do not pay are accompanied with a description of the edit that caused them to either deny or suspend. Those descriptions are used by providers to correct errors and resubmit claims for payment.

The MMIS adjudicates claims on a daily basis and runs payment cycles once a week. Payment cycles result in warrant files that are submitted to the District Treasury. All checks are generated and issued by the Treasury. The Treasury returns a file to the MMIS once checks are issued that identify check numbers and dates. The MMIS updates the payment file to include this information and maintains it as part of the permanent record.

Appendix I: Financial Accountability

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

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

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State

verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

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

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Billing validation consists of both pre- and-post payment processes. Pre-payment validation consists of edits within the MMIS claims processing logic to ensure that three conditions exist prior to paying a waiver claim. The first condition is that the beneficiary must be enrolled in the waiver on the date of service. The system verifies this by checking the beneficiary's program code for the date of service and ensuring the code is associated with the waiver. The second condition is that the provider is eligible to render waiver services to waiver beneficiaries. Providers must obtain waiver provider numbers in order to render waiver services to beneficiaries. The system checks the billing provider number and validates that it is a waiver provider type. The final prepayment validation edits verify that the services were provided in accord with limits and requirements specified in the waiver; such as that prior authorization was given for each waiver service delivered, and that the quantity of waiver services provided does not exceed limits specified in the waiver. If any of these conditions is false, the claim will be denied for payment.

Post payment validation of claims is conducted by the State Agency's Division of Program Integrity - Surveillance and Utilization Branch. Staff from this Branch annually audit claims submitted for waiver services. These audits consist of pulling a random sample of claims and then going on-site to waiver providers' offices to compare information submitted on the claims to patient care documentation. These audits always assess whether or not the service is included in the participant's approved service plan and whether evidence exists that services were provided. In instances in which documentation does not affirm either of these, the state agency recovers the payment made and returns the federal share. Random sampling of such claims is an efficient approach to validation and ensuring appropriate payment recovery because State regulations provide the state agency with the authority to extrapolate the rate of denied claims in the sample to the universe of similar claims from the provider and recover a percent of payment equal to the error rate observed in the sample.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

Yes. The State makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

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

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

The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

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

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

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

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

  Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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

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

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

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

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

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

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

4239 SPECIFIC PROVIDER REQUIREMENTS: ASSISTED LIVING SERVICES

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

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

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

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

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

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

No. The State does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

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

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- **Nominal deductible**
- **Coinsurance**
- **Co-Payment**
- **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

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

(●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	23160.56	22118.91	45279.47	67643.27	11231.11	78874.38	33594.91
2	21325.92	20316.97	41642.89	72120.36	12230.73	84351.09	42708.20

3	19764.93	18515.03	38279.96	76597.45	13230.34	89827.79	51547.83
4	18295.10	16713.09	35008.19	81074.53	14229.95	95304.48	60296.29
5	16968.00	14911.15	31879.15	85551.62	15229.57	100781.19	68902.04

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	4660	4660
Year 2	4760	4760
Year 3	4860	4860
Year 4	4960	4960
Year 5	5060	5060

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

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

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D calculates the annual average per person cost for waiver-specific services for individuals in the EPD waiver program. To project this factor for the current waiver period year 5 and the future waiver period years 1-5, we forecasted both the number of users and the utilization level for each waiver-specific service based on historical trends, while also accounting for any anticipated utilization increases/decreases. We then multiplied these two projections together to get annual anticipated total units. Multiplying this figure by the average cost per unit for each service area led to the total cost, by year, by service area. The summation of the total cost, by year, for all service areas divided by total projected unduplicated participants in the waiver program resulted in

the forecasted Factor D for the current waiver period year 5 and future waiver period years 1-5.

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

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

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

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

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

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

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

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

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

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

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

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Case Management
Homemaker
Personal Care Aide
Respite
Assisted Living
Chore Aide
Environment Accessibility and Adaptation Services
Participant Directed Goods and Services
Participant-Directed Personal Care Services
Personal Emergency Response System (PERS)

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**4749059.52**
Case Management Initial Assessment	initial assessment	110	1.20	310.11	**40934.52**	
Case Management Visit	visit	4050	7.50	125.00	**3796875.00**	
Case Management Annual Reassessment	reassessment	4050	1.00	225.00	**911250.00**	
Homemaker Total:						**1014369.30**
Homemaker	hourly	59	1637.40	10.50	**1014369.30**	
Personal Care Aide Total:						**100180628.04**
Personal Care Aide	15 minutes	3749	6549.50	4.08	**100180628.04**	
Respite Total:						**189358.18**
Respite 1-17 hours/day	15 minutes	84	549.10	4.08	**188187.55**	
Respite 18-24 hours/day	day	4	27.30	10.72	**1170.62**	
Assisted Living Total:						**963600.00**
Assisted Living	day	44	365.00	60.00	**963600.00**	
Chore Aide Total:						**9120.00**

Chore Aide	hourly	19	32.00	15.00	**9120.00**	
Environment Accessibility and Adaptation Services Total:						**25000.00**
Environment Accessibility and Adaptation Services	assessed	5	1.00	5000.00	**25000.00**	
Participant Directed Goods and Services Total:						**0.00**
Participant Directed Goods and Services	annual	0	1.00	500.00	**0.00**	
Participant-Directed Personal Care Services Total:						**0.00**
Participant-Directed Personal Care Services	15 minutes	0	0.00	4.08	**0.00**	
Personal Emergency Response System (PERS) Total:						**797060.00**
Personal Emergency Response System Installation	flat rate	518	1.00	40.00	**20720.00**	
Personal Emergency Response System Rental	month	2270	12.00	28.50	**776340.00**	

GRAND TOTAL:	**107928195.04**
Total Estimated Unduplicated Participants:	**4660**
Factor D (Divide total by number of participants):	**23160.56**
Average Length of Stay on the Waiver:	323

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**4880350.15**
Case Management Initial Assessment	initial assessment	113	1.20	309.92	**42025.15**	
Case Management Visit	visit	4162	7.50	125.00	**3901875.00**	
Case Management Annual Reassessment	reassessment	4162	1.00	225.00	**936450.00**	
Homemaker Total:						**1375416.00**
Homemaker	hourly	80	1637.40	10.50	**1375416.00**	
Personal Care Aide Total:						**92784776.54**
Personal Care Aide	15 minutes	3858	5894.60	4.08	**92784776.54**	
Respite Total:						

						223886.10
Respite 1-17 hours/day	15 minutes	87	627.10	4.08	**222595.42**	
Respite 18-24 hours/day	day	4	30.10	10.72	**1290.69**	
Assisted Living Total:						**1182600.00**
Assisted Living	day	54	365.00	60.00	**1182600.00**	
Chore Aide Total:						**9600.00**
Chore Aide	hourly	20	32.00	15.00	**9600.00**	
Environment Accessibility and Adaptation Services Total:						**25000.00**
Environment Accessibility and Adaptation Services	assessed	5	1.00	5000.00	**25000.00**	
Participant Directed Goods and Services Total:						**5000.00**
Participant Directed Goods and Services	annual	10	1.00	500.00	**5000.00**	
Participant-Directed Personal Care Services Total:						**43656.00**
Participant-Directed Personal Care Services	15 minutes	10	1070.00	4.08	**43656.00**	
Personal Emergency Response System (PERS) Total:						**981092.00**
Personal Emergency Response System Installation	flat rate	536	1.00	40.00	**21440.00**	
Personal Emergency Response System Rental	month	2806	12.00	28.50	**959652.00**	

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

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**5276477.52**
Case Management Initial Assessment	initial assessment	116	1.00	309.72	**35927.52**	
Case Management Visit	visit	4278	8.00	125.00	**4278000.00**	

Case Management Annual Reassessment	reassessment	4278	1.00	225.00	**962550.00**	
Homemaker Total:						**1426994.10**
Homemaker	hourly	83	1637.40	10.50	**1426994.10**	
Personal Care Aide Total:						**86384428.73**
Personal Care Aide	15 minutes	3991	5305.10	4.08	**86384428.73**	
Respite Total:						**264879.20**
Respite 1-17 hours/day	15 minutes	90	705.00	4.08	**258876.00**	
Respite 18-24 hours/day	day	5	112.00	10.72	**6003.20**	
Assisted Living Total:						**1401600.00**
Assisted Living	day	64	365.00	60.00	**1401600.00**	
Chore Aide Total:						**9600.00**
Chore Aide	hourly	20	32.00	15.00	**9600.00**	
Environment Accessibility and Adaptation Services Total:						**25000.00**
Environment Accessibility and Adaptation Services	assessed	5	1.00	5000.00	**25000.00**	
Participant Directed Goods and Services Total:						**10000.00**
Participant Directed Goods and Services	annual	20	1.00	500.00	**10000.00**	
Participant-Directed Personal Care Services Total:						**87312.00**
Participant-Directed Personal Care Services	15 minutes	20	1070.00	4.08	**87312.00**	
Personal Emergency Response System (PERS) Total:						**1171280.00**
Personal Emergency Response System Installation	flat rate	554	1.00	40.00	**22160.00**	
Personal Emergency Response System Rental	month	3360	12.00	28.50	**1149120.00**	

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

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**5423159.07**
Case Management Initial Assessment	initial assessment	119	1.00	309.53	**36834.07**	
Case Management Visit	visit	4397	8.00	125.00	**4397000.00**	
Case Management Annual Reassessment	reassessment	4397	1.00	225.00	**989325.00**	
Homemaker Total:						**1495764.90**
Homemaker	hourly	87	1637.40	10.50	**1495764.90**	
Personal Care Aide Total:						**80356518.00**
Personal Care Aide	15 minutes	4125	4774.60	4.08	**80356518.00**	
Respite Total:						**298602.32**
Respite 1-17 hours/day	15 minutes	93	783.00	4.08	**297101.52**	
Respite 18-24 hours/day	day	5	28.00	10.72	**1500.80**	
Assisted Living Total:						**1620600.00**
Assisted Living	day	74	365.00	60.00	**1620600.00**	
Chore Aide Total:						**10080.00**
Chore Aide	hourly	21	32.00	15.00	**10080.00**	
Environment Accessibility and Adaptation Services Total:						**25000.00**
Environment Accessibility and Adaptation Services	assessed	5	1.00	5000.00	**25000.00**	
Participant Directed Goods and Services Total:						**15000.00**
Participant Directed Goods and Services	annual	30	1.00	500.00	**15000.00**	
Participant-Directed Personal Care Services Total:						**130968.00**
Participant-Directed Personal Care Services	15 minutes	30	1070.00	4.08	**130968.00**	
Personal Emergency Response System (PERS) Total:						**1368006.00**
Personal Emergency Response System Installation	flat rate	573	1.00	40.00	**22920.00**	
Personal Emergency Response System Rental	month	3933	12.00	28.50	**1345086.00**	
				GRAND TOTAL:		**90743698.29**
				Total Estimated Unduplicated Participants:		**4960**
				Factor D (Divide total by number of participants):		**18295.10**
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						**5574738.26**
Case Management Initial Assessment	initial assessment	122	1.00	309.33	**37738.26**	
Case Management Visit	visit	4520	8.00	125.00	**4520000.00**	
Case Management Annual Reassessment	reassessment	4520	1.00	225.00	**1017000.00**	
Homemaker Total:						**1512957.60**
Homemaker	hourly	88	1637.40	10.50	**1512957.60**	
Personal Care Aide Total:						**74792228.69**
Personal Care Aide	15 minutes	4266	4297.10	4.08	**74792228.69**	
Respite Total:						**339037.44**
Respite 1-17 hours/day	15 minutes	96	861.00	4.08	**337236.48**	
Respite 18-24 hours/day	day	6	28.00	10.72	**1800.96**	
Assisted Living Total:						**1839600.00**
Assisted Living	day	84	365.00	60.00	**1839600.00**	
Chore Aide Total:						**10560.00**
Chore Aide	hourly	22	32.00	15.00	**10560.00**	
Environment Accessibility and Adaptation Services Total:						**25000.00**
Environment Accessibility and Adaptation Services	assessed	5	1.00	5000.00	**25000.00**	
Participant Directed Goods and Services Total:						**20000.00**
Participant Directed Goods and Services	annual	40	1.00	500.00	**20000.00**	
Participant-Directed Personal Care Services Total:						**174624.00**
Participant-Directed Personal Care Services	15 minutes	40	1070.00	4.08	**174624.00**	
Personal Emergency Response System (PERS) Total:						**1569320.00**
Personal Emergency Response System Installation	flat rate	587	1.00	40.00	**23480.00**	
Personal Emergency Response System Rental	month	4520	12.00	28.50	**1545840.00**	
				GRAND TOTAL:		**85858065.99**
				Total Estimated Unduplicated Participants:		**5060**

Factor D (Divide total by number of participants):	**16968.00**
Average Length of Stay on the Waiver:	365