**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. PURPOSE OF THE RENEWAL ~~Major Changes~~

Describe any significant changes to the approved waiver that are being made in this Renewal application:

The Waiver Renewal application adds a new service, amends existing service descriptions, adds a new reimbursement methodology to increase payment for assisted living services, adds new provider training requirements, and amends existing provider qualification verification standards. The Renewal Application streamlines the EPD Waiver recertification process for continued enrollment in the EPD Waiver. Lastly, the Transition Plan was also modified to reflect the changes approved in the Statewide Transition Plan.

The major changes are as follows:

The Waiver Renewal adds a new service- Community Transition Services.

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institution or other long term care facility to a more integrated and less restrictive community setting. Allowable expenses are those necessary to enable an individual to establish a basic household that does not constitute room and board and may include: (a) application fees and security deposits in the amount of the first month’s rent or greater that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure needed resources.

The personal care aide service description was amended to include “safety monitoring” among the personal care aide’s duties. Safety-monitoring, as an independent stand-alone function, is currently outside of the scope of personal care services. Adding safety monitoring to a personal care aide’s scope of duties will allow aides to bill for the time they spend monitoring the beneficiary closely to prevent beneficiary harm, injury or accidents.

The recertification process for enrollment in the EPD Waiver will be streamlined to reduce the burden on beneficiaries and ensure continuity of care. Specifically, once determined initially eligible for the waiver based upon a registered nurse conducted face to- face, conflict free assessment of functional, cognitive and skilled care needs, a new, face-to-face reassessment of needs shall only be required if there has been a change in the beneficiary’s health status. If there is no change in health status, the case manager shall attest that the individual continues to meet the nursing facility level of care and communicate the attestation to DHCF’s designated entity for a financial disposition of Medicaid eligibility. As a quality check, beginning one year from the date of approval of this waiver and on an annual basis thereafter, DHCF or its designee shall conduct face-to-face reassessments of a random sample of beneficiaries who had no change in health status and whose continued eligibility for the waiver is based upon a case manager’s attestation.

The renewal application will modify these two service definitions to clarify that a participant may receive the full number of assessed hours of PDCS services, without regard to the limitations governing hours of Medicaid State Plan agency-based PCA services, and to require execution of a Medicaid provider agreement for all vendors of individual-directed goods and services. The involuntary termination process for the participant-directed services program will be revised to include provisions related to substantiated findings of fraud, theft or other criminal behavior. These modifications are based on the District’s experience during its initial year of enrollment of waiver participants in the participant-directed services option.

The Assisted Living Reimbursement Methodology was amended and increases provider payments from sixty ($60) dollars per day to one hundred and fifty five dollars ($155) per day, effective July 2017.

The renewal application modifies provider qualification and provider qualification verification criteria. All Adult Day Health, Assisted Living providers, and Home Care Agencies providing EPD Waiver services shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.

In the approved EPD Waiver, DHCF’s Long Term Care Administration and DHCF’s Division of Public and Private Provider Services will verify provider readiness during initial provider application review process as well as the re-enrollment process (every three years). In the EPD Waiver renewal application, DHCF will propose conducting telephone surveys in lieu of on-site visits to verify provider readiness for out-of-state providers.

Lastly, the Transition Plan included under Attachment #2 was updated to explain any assessment, compliance, and monitoring processes related to HCBS settings as reflected in the most recently approved Statewide Transition Plan.

These changes are cumulatively expected to improve service delivery and options for District of Columbia residents who are elderly and individuals with physical disabilities.

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

1. **Request Information (1 of 3)**
   1. 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).
   2. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):

**Elderly & Persons With Disabilities Waiver Renewal 01/04/2012**

* 1. Type of Request: Amendment

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

 **3 years  5 years**

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

### Renewal of Waiver:

##### Provide the information about the original waiver being renewed

0334

**Base Waiver Number: Amendment Number**

01/04/2012

##### (if applicable):

**Effective Date:** *(mm/dd/yy)* **Waiver Number: DC.0334.R03.00 Draft ID: DC.03.03.00**

03

Renewal Number:

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



Regular Waiver

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

1/4/2017

### Approved Effective Date: 01/04/12

**1. Request Information (2 of 3)**

* 1. **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 the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

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



1. **Request Information (3 of 3)**
   1. **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:



* 1. Dual Eligibility for Medicaid and Medicare

Check if applicable:

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

1. **Brief Waiver Description**

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

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

**2. BRIEF WAIVER DESCRIPTION**

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

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

OBJECTIVES:

1) Ensure the target populations remain in home and community-based settings that meet all of the

requirements of the HCBS regulation under 42 CFR 441.301

2) Ensure the target populations have access to supports that are participant-directed.

3) Enhance the quality of life for the target populations by preserving their independence and

relationships with family and friends.

4) Expand the range of long-term services and supports available for the target populations. Implement a

conflict-free case management and person-centered planning delivery process in accordance with the

requirements of 42 CFR 441.301

ORGANIZATIONAL STRUCTURE: DHCF administers the waiver and its processes

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

1) The District of Columbia’s Office on Aging, Aging Disability and Resource Center is the first point

of contact in the pathway for a DC resident to request long term care services and supports. The

ADRC collects general information and demographics and counsels the Applicant on available

services. If a person requests long-term care services, an Enrollment Specialist (ES) will be assigned

to assist the person with the application process for the EPD Waiver Program.

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

the following documents-

a) physician authorization

b) 30 AW to inform ESA that the applicant is applying for EPD Waiver services

c) Rights and Responsibilities

d) Freedom of Choice form and Attestation/Case Management Provider Selection Form

e) Proof of Residency

f) Proof of Income and other supporting financial documentation; and

g) LTC Application and

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

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

5) When the LOC is determined via the assessment tool, the ES is responsible for ensuring the

information is transmitted to ESA and ESA is responsible for determining financial eligibility

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

7) The disposition of financial assessment is sent to DHCF and ADRC, and eligibility

notices are sent to the applicant or authorized representative

8) The ES contacts the selected CMA on behalf of the applicant, and secures acceptance. The ES will

contact CMAs until the applicant is accepted

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

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

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

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

13) The recertification process for enrollment in the EPD Waiver will be streamlined to reduce the burden on beneficiaries and ensure continuity of care. Specifically, once determined initially eligible for the waiver based upon a registered nurse conducted face to- face, conflict free assessment of functional, cognitive and skilled care needs, a new, face-to-face reassessment of needs shall only be required if there has been a change in the beneficiary’s health status. If there is no change in health status, the case manager shall attest that the individual continues to meet the nursing facility level of care and communicate the attestation to DHCF’s designated entity for a financial disposition of Medicaid eligibility.

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

# Components of the Waiver Request

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

* 1. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.
  2. **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.
  3. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
  4. **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).
  5. **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.*

* 1. **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.
  2. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
  3. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.
  4. **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.
  5. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

# Waiver(s) Requested

* 1. **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**.
  2. **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**

* 1. **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:*



# Assurances

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

* 1. **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**.
  2. **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**.
  3. **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**.

##### 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.
  1. **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**.
  2. **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.
  3. **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.
  4. **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.
  5. **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.
  6. **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.

# Additional Requirements

#### Note: Item 6-I must be completed.

* 1. **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.
  2. **Inpatients**. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in- patients of a hospital, nursing facility or ICF/MR.
  3. **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

##### 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**.

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

**Appendix C**.

* 1. **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.
  2. **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.
  3. **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.

* 1. **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**.

##### **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.

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.

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

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

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

• Publication of Public Notice of Proposed Changes in the Renewal Application, published in May 6th Register

* thirty day (30) day public comment period ran from May 9th through June 8th

•DHCF held a public forum on June 1st to review any proposed changes in the Renewal Application

• Copies of this notice and the proposed Waiver Amendment were published on the DHCF website at <http://dhcf.dc.gov>.

•Stakeholders had two opportunities to submit comments-

* In-person during the public forum held on June 1, 2016
* Written comments submitted to the Long Term Care Administration Director
* Comments were also addressed during the monthly EPD Waiver stakeholder meetings
  1. **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.
  2. **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.

# Contact Person(s)

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

**Last Name:**

Gray

**First Name:**

Ieisha

**Title:**

Director, Administration of Long Term Care

**Agency:**

Department of Health Care Finance

**Address:**

441 4th Street, N.W. 10th Floor North Capitol Street,

**Address 2:**

**City:**

Washington

**State: Dist. of Columbia**

**Zip:**

20001

**Phone: Ext:  TTY**

(202) 442-5818

**Fax:**

(202) 442-8114

**E-mail:**

Ieisha.Gray@dc.gov

##### 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:** |  |  |  |

# 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:**

**Submission Date:**

Claudia Schlosberg

##### State Medicaid Director or Designee

September 1, 2016.

**Last Name:**

Schlosberg

**First Name:**

Claudia

**Title:**

Senior Deputy Director - Medicaid

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# Attachment #1: Transition Plan

##### Specify the transition plan for the waiver:

The renewal is a continuation of the existing waiver.

# Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Continued from Appendix B, Quality Improvement Strategy:

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

1. Functional- impairments including assistance with activities of daily living such as bathing, dressing, eating/feeding;
2. Clinical supports-skilled nursing or other skilled care (e.g., wound care, infusions), sensory impairments, other health diagnoses; and
3. Behavioral- ability to understand others, communications impairments, presence of behavioral symptoms like hallucinations, and/or delusions.

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

Completion of the assessment will yield a final total score determined by adding up the individual scores from the three domains.

To be eligible for reimbursement of EPD Waiver services, an individual seeking Waiver services has to obtain a score of nine (9) or higher, which is equivalent to a nursing facility level of care.

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

The recertification process for enrollment in the EPD Waiver will be streamlined to reduce the burden on beneficiaries and ensure continuity of care . Specifically, once determined initially eligible for the waiver based upon a registered nurse conducted face to- face, conflict free assessment of functional, cognitive and skilled care needs, a new, face-to-face reassessment of needs shall only be required if there has been a change in the beneficiary’s health status. If there is no change in health status, the case manager shall attest that the individual continues to meet the nursing facility level of care and communicate the attestation to DHCF’s designated entity for a financial disposition of Medicaid eligibility. As a quality check, beginning one year from the date of approval of this waiver and on an annual basis thereafter, DHCF or its designee shall conduct face-to-face reassessments of a random sample of beneficiaries who had no change in health status and whose continued eligibility for the waiver is based upon a case manager’s attestation.

# 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**

* 1. **Oversight of Performance.**
     1. **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.**



* + 1. **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**

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

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

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

*and A-6.:*

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

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

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

DHCF utilizes a Quality Improvement Organization (QIO) for some waiver operational and administrative functions. The QIO functions for the EDP Waiver are to prior authorize EPD Waiver services,

perform a person-centered individualized service plan reviews, to determine if the service plan and the services required are appropriate to meet the needs of the participant and if the services are correctly identified.

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

# Appendix A: Waiver Administration and Operation

* 1. **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

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

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

# Appendix A: Waiver Administration and Operation

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

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

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

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

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