**APPENDIX B- PLEASE NOTE\_- PROPOSED CHANGES ARE IN TRACK**

**Appendix B: Participant Access and Eligibility**

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

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



65

18

64

**Maximum Age**

**Target Group**

**Included**

**Target SubGroup**

**Minimum Age Maximum Age No Maximum**

**Limit Age Limit**

**Aged or Disabled, or Both - General**

**Aged**

**Disabled (Physical) Disabled (Other)**

**Aged or Disabled, or Both - Specific Recognized Subgroups**

**Brain Injury HIV/AIDS**

**Medically Fragile**



**Technology Dependent**

**Mental Retardation or Developmental Disability, or Both**

**Autism**

**Developmental Disability Mental Retardation**

**Mental Illness**

**Mental Illness**

**Serious Emotional Disturbance**

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

The target populations are inclusive of elders and individuals with physical disabilities who meet at least the functional criteria for admission to the nursing facility. Individuals that participate in the EPD waiver must live in a private residence, apartment, or an assisted living facility

1. **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 individuals with physical disabilities enrolled in the EPD waiver is age 64. The age for elders enrolled in the waiver is 65 and over. Therefore, when a 64 year-old individual with a physical disability turns 65 years of age, they transition into the elder waiver category which facilitates a continuity of care.

# Appendix B: Participant Access and Eligibility B-2: Individual Cost Limit (1 of 2)

1. **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.

1. **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:



1. **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)**

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

**Table: B-3-a**

**Waiver Year Unduplicated Number of Participants**

**Year 1** 5160

**Year 2**  5260

**Year 3**  5360

**Year 4**  5460

**Year 5**  5560

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

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

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

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

**Table: B-3-b**

**Waiver Year Maximum Number of Participants Served At Any Point During the Year**

**Year 1** 4639

**Year 2** 4763

**Year 3** 4888

**Year 4** 5015

**Year 5** 5143

# Appendix B: Participant Access and Eligibility

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

1. **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**

**Community transitions of institutionalized persons Enrollees aging out of HSCSN enrollment**

# 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):

**Waiver Year**

Year 1

Year 2

Year 3

Year 4 (renewal only) Year 5 (renewal only)

**Capacity Reserved**

60

60

60

60

60

**Community transitions of institutionalized persons**

**Purpose** *(describe):*

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

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

**Describe how the amount of reserved capacity was determined:**

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

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

**Waiver Year**

Year 1

Year 2

Year 3

Year 4 (renewal only) Year 5 (renewal only)

**Capacity Reserved**

60

60

60

60

60

**Appendix B: Participant Access and Eligibility**

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

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

**Enrollees aging out of HSCSN enrollment**

**Purpose** *(describe):*

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

Describe how the amount of reserved capacity was determined:

The DHCF Division of Research and Rate Setting Analysis, Health Care Policy and Research Administration, ran a report of all beneficiaries in the EPD waiver between ages 22-30 to gauge an approximate number of participants in this waiver to help determine projections for the next five (5) years for this target group. The results yielded a total of 145 individuals with 853/853Q program code with eligibility begin dates of January 1, 2006 or later. DHCF also contacted its primary managed care organization, the Health Care for Children with Special Needs (HSCSN), which coordinates and provides comprehensive health services to beneficiaries with special needs from birth through age 26 to get their data of how many young people age out from their program into the EPD waiver. 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**

Year 1

Year 2

Year 3

Year 4 (renewal only) Year 5 (renewal only)

**Capacity Reserved**

15

15

15

15

15

**Appendix B: Participant Access and Eligibility**

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

1. **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.**

1. **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:



1. **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: 60 beneficiaries for individuals transitioning to the community from institutions and 15 beneficiaries who are aging out of HSCSN enrollment as EPSDT enrollees or are eligible to enroll in the EPD waiver. Once the reserved capacities are established, there are no additional preferences and waiver participation is allocated on a first-come, first-served basis.

# Appendix B: Participant Access and Eligibility

### 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**

* 1. Miller Trust State.

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

 **No  Yes**

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

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

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

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

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

*Select one*:

### 100% of the Federal poverty level (FPL)

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

##### Specify percentage:

 **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in**

**§1902(a)(10)(A)(ii)(XIII)) of the Act)**

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

 Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage

**Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

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

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

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

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



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

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

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

*Select one and complete Appendix B-5.*

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

**under 42 CFR §435.217**

*Check each that applies*:

 **A special income level equal to:**

*Select one*:

### 300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

### A dollar amount which is lower than 300%.

Specify dollar amount:

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

### Medically needy without spend down in States which also provide Medicaid to recipients of SSI (42

**CFR §435.320, §435.322 and §435.324)**

 Medically needy without spend down in 209(b) States (42 CFR §435.330)  Aged and disabled individuals who have income at:

*Select one*:

 **100% of FPL**

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

Specify percentage amount:

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

*Specify:*



**Appendix B: Participant Access and Eligibility**

**B-5: Post-Eligibility Treatment of Income (1 of 4)**

*In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under*

*§1924 of the Act to protect a personal needs allowance for a participant with a community spouse.*

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

X **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)

X 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)*

*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 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 4)**

### 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:

* 1. **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:



* 1. **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.

X The amount is determined using the following formula:

*Specify:*

*The Minimum Monthly Maintenance Needs Allowance (MMMNA) (this amount is established annually*

*by CMS); plus Excess shelter allowances (may include rent or mortgage payments, electric, gas, heating oil, water, and a standard telephone deduction of $21.00); minus The community spouse's countable income (determined using SSI based methodologies)*

*(MMMNA + excess shelter expenses - community spouse's countable income)*



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

### (remove selection) Not Applicable (see instructions) AFDC need standard

 X 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:*



* 1. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:** 
     1. Health insurance premiums, deductibles and co-insurance charges
     2. 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:

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

### X The State does not establish reasonable limits.

 The State establishes the following reasonable limits

*Specify:*



**Appendix B: Participant Access and Eligibility**

**B-5: Post-Eligibility Treatment of Income (3 of 4)**

1. **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 4)**

1. **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-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*

1. *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.*
   1. **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:
      1. 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

* + 1. **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:*



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

 Directly by the Medicaid agency

 **By the operating agency specified in Appendix A**

 **By an entity under contract with the Medicaid agency**

*Specify the entity:*

Performance of Medicaid Level of Care is conducted initially and upon annual reassessment by the District’s Long Term Care Services and Supports Contractor

 **Other**

*Specify:*

**c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the

educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

**The initial Level of Care is performed by:**

* Registered Nurse, Licensed in the State

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

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

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

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

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

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.

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

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

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

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



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

evaluation process, describe the differences:

For all persons seeking to enroll in the Waiver, the ADRC or its designee will be assigned to assist the person with the application process for the EPD Waiver Program. Once physician certification is received, the ADRC or its designee, is responsible for assisting the applicant request that a level of care assessment (evaluation) using the standardized assessment tool will be conducted by the Long-Term Care Services and Supports Contractor (LTCSS Contractor). When the LOC is approved via the assessment tool, the ADRC or its designee is responsible for ensuring that the information is transmitted to ESA and ESA is responsible for determining financial eligibility.

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

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

The reassessment process is similar to the initial assessment process, however, during the reassessment period, the ADRC does not play a role. The DHCF’s Long Term Care Administration sends a notice to the CMAs at least one hundred and twenty (120) days in advance of recertification to alert the Case Management Agencies of the recertification due dates.

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.

Once it has been established that the individual meets or continues to meet nursing facility level of care, ESA is responsible for determining financial eligibility.

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

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

* Every three months
*  Every six months

 **Every twelve months**

 **Other schedule**

*Specify the other schedule:*



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

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

 The qualifications are different.

*Specify the qualifications:*



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

In order to streamline the recertification process, 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. The DHCF’s Long Term Care Administration sends a notice to the CMAs at least one hundred and twenty (120) days in advance of recertification to alert the Case Management Agencies of the recertification due dates.

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 (ESA) for a financial disposition of Medicaid eligibility.

ESA is subsequently responsible for determining financial eligibility after the LOC is approved via the assessment tool during the reassessment, or after the CM communicates the attestation verifying there has been no change in the EPD Waiver participant’s health needs.

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

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

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

**Appendix B: Evaluation/Reevaluation of Level of Care Quality Improvement: Level of Care**

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

1. **Methods for Discovery: Level of Care Assurance/Sub-assurances**
   1. **Sub-Assurances:**
      1. ***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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 to the 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:**Electronic Case Management System**

**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):*

**State Medicaid Agency**

**Operating Agency**

**Frequency of data collection/generation**

*(check each that applies):*

**Sampling Approach**

*(check each that applies):*

**Weekly**

**100% Review**

**Monthly**

**Sub-State Entity**

**Quarterly**

**Less than 100%**

**Review**

**Representative Sample**

Confidence Interval =

**Other**

Specify:

**Annually**

**Stratified**

Describe Group:

**Continuously and**

**Other**



**Ongoing**

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:

* + 1. ***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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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:PLEASE NOTE- THIS PM WAS DELETED**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**QIO System and Casenet**



**Responsible Party for**

**data collection/generation** *(check each that applies):*

**State Medicaid Agency**

**Operating Agency**

**Frequency of data**

**collection/generation**

*(check each that applies):*

**Sampling Approach**

*(check each that applies):*

**Weekly**

**100% Review**

**Monthly**

**Sub-State Entity**

**Quarterly**

**Less than 100%**

**Review**

**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:

* + 1. ***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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 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):*

**State Medicaid Agency Operating**

**Agency**

**Sub-State Entity**

**Frequency of data**

**collection/generation** *(check each that applies):*

**Sampling Approach***(check each*

*that applies):*

**Weekly**

**100% Review**

**Monthly**

**Less than 100% Review**

**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



**Other**

Specify:

**Annually**

Interval =

95%, 5%

**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 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:

* 1. 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

**Appendix H**

**ii. Describe the process to periodically evaluate the Quality Improvement Strategy**

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

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

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

The performance status for each measure is discussed at the monthly Quality Management Committee (QMC) meeting. Committee members include managers and staff within various administrations at DHC.

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

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

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

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

The quality strategy will complete and implemented by December 2017.

1. **Methods for Remediation/Fixing Individual Problems**
   1. 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 Administration of Long Term Care (DLTC), Elders and Persons with Physical Disabilities Unit (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.

* 1. **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:

1. **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**

The Quality Improvement Strategy is complete and implemented- please see Appendix H.

**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:*

1. *informed of any feasible alternatives under the waiver; and*
2. *given the choice of either institutional or home and community-based services.*
3. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver

services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

1. **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**

1. **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