APPENDIX- C

SERVICE DESCRIPTIONS

1) Adult day health services

Service Type: Statutory service

Check this box:

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

Service Title: Adult day health services

Service Definition:
Adult day health services are designed to encourage older adults enrolled in the EPD Waiver to live in the community by offering non-residential medical supports and supervised, therapeutic activities in an integrated community setting, to foster opportunities for community inclusion, and to deter more costly facility-based care.

Adult day health services includes the following services: medical and nursing consultation services including health counseling to improve the health, safety and psycho-social needs of persons enrolled in the waiver; individual and group therapeutic activities, including social, recreational and educational activities provided by licensed therapists such as an occupational or physical therapist, and speech language pathologist; social service supports provided by a social service professional including consultations to determine the person's need for services, offering guidance through counseling and teaching on matters related to the person's health, safety, and general welfare; direct care supports services to provide direct supports like personal care assistance, offering guidance in performing self-care and activities of daily living, instruction on accident prevention and the use of special aides; and medication administration services provided by a Registered Nurse (RN) including administration of medication and/or assistance in self administration of medication as appropriate. Persons enrolled in the waiver will also be provided with nutrition and meal services consisting of nutritional education, training, and counseling to persons enrolled and their families, and provision of meals and snacks while in attendance at the day setting.

Additionally, in accordance with 42 CFR 441.301, all adult day health service providers will meet the "setting requirements", as verified by the DHCF EPD Waiver Provider Readiness Review process.

These include the following:

(i) The setting is integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

(ii) The setting is selected by the person from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.

(iii) Ensures a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

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

In addition to the Provider Readiness Reviews, the District will utilize an additional assessment process to ensure that the persons seeking to receive services from the adult day health providers under the EPD waiver are living in settings that comply with the provisions of the HCBS federal regulation. DHCF will use the nurses that conduct face-to-face, conflict-free, standardized assessments of applicants seeking long term care services and supports described under Appendix B (evaluation/revaluation of care) to determine the person’s level of need for services under the Waiver. The nurses will also capture additional information to verify and ensure that the person who receives adult day services is living in an environment that comports with the HCBS standards reflected above (441.301 c (4) (i-v)) and the additional standards that pertain to provider-owned or controlled residential settings as set forth under 441.301 c(4) (vi). Administration of the assessment process during the face-to-face assessments conducted in a person’s residence ensures that the persons accessing adult day services under the EPD waiver live in settings that promote community living.

These include the following:

(i) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the person receiving services, and the person has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;

(ii) Each person has privacy in their sleeping or living unit:

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

(iii) Persons have the freedom and support to control their own schedules and activities, and have access to food at any time;

(iv) Persons are able to have visitors of their choosing at any time;
(v) The setting is physically accessible to the person; and

(vi) Any modification of the additional conditions specified in §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(1) Identify a specific and individualized assessed need;
(2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan;
(3) Document less intrusive methods of meeting the need that have been tried but did not work;
(4) Include a clear description of the condition that is directly proportionate to the specific assessed need;
(5) Include regular collection and review of data to measure the ongoing effectiveness of the modification;
(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
(7) Include the informed consent of the person; and
(8) Include an assurance that interventions and supports will cause no harm to the individual.

Limitations in amount, duration, and scope:

1) A provider will not be reimbursed for adult day habilitation services if they do not meet the "setting" requirements under 42 CFR 441.301 as verified by the Provider screening and Readiness Review.

2) A provider shall not be reimbursed for adult day habilitation services if the person enrolled in the waiver is concurrently receiving the following services:

(a) Day Habilitation or Individualized Day Supports under the 1915 (c) Waiver for Individuals with Intellectual and Developmental Disabilities (ID/DD);

(b) Intensive day treatment or day treatment mental health rehabilitative services (MHRS) under the District of Columbia State Plan for Medical Assistance (State Plan);

(c) Personal Care Aide services; (State Plan or 1915 (c) waivers) or

(d) Services funded by the Older Americans Act of 1965, Title IV, Public Law 89-73, 79 Stat. 218, as amended; Public Law 97-115, 95 Stat. 1595; Public Law 98-459, 98 Stat. 1767; Public Law 100-175; Public Law 100-628, 42 U.S.C. 3031-3037b; Public Law 102-375; Public Law 106-501; and

(e) 1915 (i) State Plan Option services under the State Plan

3) Additionally, a provider shall not be reimbursed for adult day health services if the person is receiving intensive day treatment mental health rehabilitation services during a twenty-four (24) period that immediately precedes or follows the receipt of adult day health services to ensure that the person is receiving services in the setting most appropriate to his/her clinical needs. Adult day health services shall not be provided for more than five (5) days per week and for more than eight (8) hours per day.

Provider Qualifications:

License:
All individual health practitioners shall be licensed in accordance with the District of Columbia's Department of Health's Health Occupations Revisions Act. "Health Occupations Revision General Amendment Act of 2009" as incorporated into Title 3, Chapter 12 of the District of Columbia Official Code.

Certificate:
Have a valid certificate of Need (CON) as determined by the District of Columbia State Health Planning and Development Agency.

Other Standards:

(1) Have a Medicaid Provider Agreement with DCHF to be enrolled as an adult day health provider ;

(2) Meet DHCF's Provider Readiness Review process which will ensure that the following are in place:

   (a) A service delivery plan to render delivery of adult day health services;

   (b) A staffing and personnel training plan in accordance with any of DHCF's requirements;

   (c) Policies and procedures in accordance with any requirements set by DHCF; and

   (d) Data elements for ensuring compliance with the home and community-based setting requirements in accordance with 42 CFR 441.301 respectively.

Entity responsible for verification –DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure provider qualifications. The provider screening and readiness review will include an on-site visit to ensure that the elements of the Provider Readiness Review are in place. Additionally, provider qualifications are reviewed and verified b DHCF Division of Public and Private Provider Services.

Frequency of verification:
DHCF's Long Term Care Administration will verify initial reviews at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years).

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

☐ **Legally Responsible Person**

☐ **Relative (check relative)**

☐ **Legal Guardian**

2) **Homemaker**

Service Type: Statutory service

Check this box:

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

Service Title: Homemaker

Service Definition *(Scope):*
Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent and/or unable to manage the home and/or care for him or herself and/or others in the home.

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

1) Homemaker services may be provided only in cases where neither the individual nor anyone else in the household is able to provide the service or pay for the provision of the service.

2) An individual or family member other than the person's spouse, parent of a minor child, any other legally responsible relative, or court-appointed guardian may provide homemaker services. Legally responsible relatives do not include parents of an adult child, so parents of an adult child enrolled in the Waiver are not precluded from providing Homemaker services.

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

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

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

☐ **Legally Responsible Person**
☐ **Relative (check relative)**
☐ **Legal Guardian**

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category: Change Individual to Agency or Business
Individual

Provider Type:

Home care agencies, Licensed provider of housekeeping services

Provider Qualifications

License *(specify):*

Be a home care agency licensed pursuant to the requirements for home care agencies as set forth in the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code, §§ 44-501 *et seq*. (2005 Repl. & 2012 Supp.)), and implementing rules; or

Have a general business license issued by the Department of Consumer and Regulatory Affairs to perform housekeeping services in the District of Columbia.

Certificate *(specify):*

Other Standard *(specify):*

Provider Standards:

1) Be enrolled as a Medicare home health agency qualified to offer skilled services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 CFR § 484; or

2) Be enrolled as an EPD Waiver Provider of Homemaker services; and
3) Have a current Medicaid provider agreement on file with the DHCF before providing any waiver services;

Individual Homemaker standards:

1) Be at least 18 years of age;
2) Be able to successfully communicate with the person receiving EPD Waiver services;
3) Each person providing homemaker services shall complete a 75-hour initial training course, hold a Home Health Aide or Homemaker certificate from a training institution approved by the District of Columbia Nursing Aide Training Program, and shall have successfully completed a competency evaluation;
4) Undergo twelve (12) hours of continuing education annually;
5) Maintain an updated CPR certificate; and
6) Have a criminal background check.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCF's Long Term Care Administration will conduct an initial provider screening and provider readiness review to ensure provider qualifications. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Frequency of Verification:

DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review verify initial reviews at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years).

3) Personal Emergency Response System (PERS)

Service Type: Other

Check this box:

◉ **(x) Service is included in the approved waiver. There is no change in service specifications**

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

( ) Service is not included in the approved waiver.

Service Title:
Personal Emergency Response System (PERS)

Service Definition *(Scope):*

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

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

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

1) No PERS will be provided for persons who are unable to understand and demonstrate proper use of the system. No PERS will be provided to persons enrolled in the Waiver who live with an individual who assumes responsibility for the safety of the recipient.

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

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

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

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

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

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

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

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

☐ **Legally Responsible Person**
☐ **Relative (check relative)**
☐ **Legal Guardian**

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

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

Provider Category: Change to Business
Agency

Provider Type Business

Provider Qualifications

License *(specify):*
Business in good standing

Certificate *(specify):*
NA

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

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure provider qualifications. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Frequency of Verification:
DHCF's Long Term Care Administration will verify initial reviews at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years).

3) **Respite**

Service Type: Statutory service

Check this box:

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

Service Title: Respite

Service Definition *(Scope):*

Services provided to persons enrolled in the waiver who are unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those individuals who normally provide care for the person.

Federal financial participation is not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite services may cover the range of activities associated with the Personal Care Aide role or the Homemaker role. These include, but are not limited to the following activities:

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

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

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

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

3) Respite services shall not be provided to persons who have no primary caregiver that is

responsible for the provision of the person's s care on an ongoing basis.

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

5) An individual or family member other than a person's spouse, parent of a minor child, any other legally responsible relative, or court-appointed guardian may provide respite services. Legally responsible relatives do not include parents of an adult child, so parents of an adult child enrolled in the Waiver are not precluded from providing respite.

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

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

☑ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative (check relative)**

☐ **Legal Guardian**

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Home Care Agency

Provider Qualifications

License *(specify):*

Be a home care agency licensed pursuant to the requirements for home care agencies as set forth in the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code, §§ 44-501 *et seq.* (2005 Repl. & 2012 Supp.)), and implementing rules

Certificate *(specify):*

Staff providing respite care services must be certified as home health aides or a personal care aides in accordance with Chapter B-39 of Title 22-B of the D.C.M.R.

Staff providing respite care must complete twelve hours [12] of continuing education annually.

Other Standard *(specify):*

1) Be enrolled as a Medicare home health agency qualified to offer skilled services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 CFR § 484; and

2) Have a current Medicaid provider agreement on file with DHCF before providing any waiver services.

4) The home care agency must develop and implement an initial intake protocol that assesses the person's respite needs and the appropriate level of care required to meet the person's needs. This initial intake assessment must be conducted by a Registered Nurse (RN) who is: (a) duly licensed to practice in the District of Columbia, and is (b) employed by the home care agency. A copy of the initial intake assessment must be on file with the home care agency.

The initial assessment conducted by the R.N. must: (a) establish a written emergency notification plan for each person receiving respite care services; and (b) document that the emergency notification requirement must be kept on file with the home care agency for a period of not less than ten (10) years.

5) An individual providing respite services may not leave the home or place of residence of the person during the period of time which respite care is being provided, unless the home care agency that is responsible for providing the services replaces such caregiver prior to the caregiver removing himself from the person's 's home or primary place of residence.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure provider qualifications. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Frequency of Verification:

DHCF's Long Term Care Administration will verify initial qualified provider status reviews at least annually. DHCF's Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years).

5) Chore Aide

Service Type: Other Services

Check this box:

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

Service Title: Chore Aide

Service Definition *(Scope):*
Chore Aide services consist of heavy house-hold chores to maintain the home in a clean, sanitary, and safe environment, including washing floors, windows, and walls, tacking down loose rugs, and tiles, and moving heavy items of furniture in order to provide for the person's and other individual provider's safe entry and exit. .Ideally, the chore aide prepares the home environment so as to be safe and clean that make the way for more routine and ongoing routine

homemaker services. This includes heavy house cleaning of the household so as to initially ensure the homemaker can conduct light household cleaning on a more routine basis.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A unit is a one hour spent performing allowable task(s). Maximum amount of service permitted under the waiver is 32 units (quantity of four, eight-hour days) and is strictly a one-time service for persons in the EPD waiver. Service shall be limited to one (1) occurrence per person. An occurrence is defined as any number of units between one to thirty two (1 – 32) units per person receiving Chore Aide services. Reimbursement for chore aide services may not be claimed by providers who provide services in residences where another party is otherwise responsible for the provision of the service, such as group home providers.

Chore aide services are provided only in cases where neither the person receiving services nor Anyone else in the household is able to provide the service or pay for the provision of the service. Chore aide task must be performed in accordance with an individualized Services Plan [ISP] In the case of rental property and residential facility, the responsibility of the landlord and/or homeowner, pursuant to the lease agreement, [or other applicable laws and regulations] must be examined (by the case manager) prior to the authorization of chore aide services. It is the responsibility of the case manager to ensure that the requisite documents have been reviewed prior to ordering chore aide services under the ISP. DHCF may grant or deny exceptions to the number of units allowed for a person's use of Chore Aide services.

An individual or family member other than the person's spouse, parent of a minor child, any other legally responsible relative, or court-appointed guardian may provide chore aide services. Legally responsible relatives do not include parents of an adult child, so parents of an adult child enrolled in the Waiver are not precluded from providing chore aide services.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Aide

Provider Category:

Provider Type:
Home Care Agency; or Licensed provider of housekeeping services

Provider Qualifications

License *(specify):*
Be a home care agency licensed pursuant to the requirements for home care agencies as set forth in the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code, §§ 44-501 *et seq*. (2005 Repl. & 2012 Supp.)), and implementing rules; or

Have a general business license issued by the Department of Consumer and Regulatory Affairs to perform housekeeping services in the District of Columbia

Certificate *(specify):*
Staff providing Chore services must successfully complete a Homemaker or Home Health Aides Training and Certification Program.

Other Standard *(specify):*
1) Be enrolled as a Medicare home health agency qualified to offer skilled services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 CFR § 484; or

2) Be enrolled as an EPD Waiver Provider of Chore Aide Services; and

3) Have a current Medicaid provider agreement on file with DHCF before providing any waiver services

4) Agencies must have bylaws or similar documents regulating conduct internal affairs Policies and Procedures

5) Individual Chore Aide worker standards are as follows:

- The home care and/or home health agency, licensed provider of housekeeping services must ensure that each chore aide providing services to persons enrolled under the Waiver has successfully completed a 40-hour initial training course which meets training guidelines for Level 1 Home care workers from a Home Care University. Such training must include a component on the safe use of household chemicals (including dangerous mixtures and working with combustible agents.) Initial training must be completed prior to making a chore aids assignment to a person's home. Require chore aides to complete a minimum of six (6) hours of continuing education on an annual basis.
- Chore aides must have a criminal background check
- Chore services must include a pre- and post-cleaning inspection of the home by the Home Care Agency, licensed business providing housekeeping services, and documentation indicating that the home environment has been placed in a state of readiness for ongoing, routine housekeeping (i.e homemaker, and/or personal care aide services). Chore services will not be reimbursed by DHCF unless the Long Term Care Administration is provided with pre-and-post-cleaning documentation.

Verification of Provider Qualifications

DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure provider qualifications of Home care agency. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Entity Responsible for Verification:

DHCF's Long Term Care Administration will verify initial qualified provider status reviews at least annually. DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years).

6) Personal Care Aide

Service Type: Statutory service

Check this box:

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

Service: Personal Care Aide

Service Definition *(Scope):*
Tasks include assistance with activities of daily living and instrumental activities of daily living. Services involving assistance with one or more activities of daily living that is rendered by a qualified personal care aide under the supervision of a registered nurse. The scope, service authorization, and nature of these services do not differ from personal care services furnished under the State plan. The allowable tasks and provider qualifications specified in the State plan apply.

~~Personal Care Aide (PCA) services include the following tasks: cueing or hands-on assistance with performance of routine activities including bathing, grooming, assistance with toileting, or bed pan use; changing urinary drainage bags; assisting recipients with self-administered medications (aide may remind bur cannot administer the medication to the recipient); reading and recording temperature, pulse, and respiration; observing and documenting the recipient's status and verbally reporting to the RN or the case manager the findings immediately for emergency situations and within four hours for other situations; accompanying the person to medically-related appointments or place of employment and recreational activities if approved in the person's plan of care; shopping for items to promote the recipient's nutritional status and other health needs; recording and reporting to the supervisory health professional and case manager any changes in the recipient's physical condition, behavior, or appearance;~~

~~Tasks include assistance with activities of daily living and instrumental activities of daily living. Services involving assistance with one or more activities of daily living that is rendered by a qualified personal care aide under the supervision of a registered nurse.~~

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

1) Limitations do not differ from any established under the Medicaid State Plan. In accordance with the State Plan, all PCA services must be prior authorized. To be eligible for PCA services, a person must:

   a) Be in receipt of a written order for PCA services, signed by a physician or Advanced Practice Nurse who: (1) enrolled in Medicaid and (2) has had a prior professional relationship with the person that included an examination(s) provided in a hospital, primary care physician's office, nursing facility, or at the person's home prior to the prescription of the personal care services.

   b) Be unable to independently perform one or more activities of daily living for which personal care services are needed as established by the face-to face assessment conducted by DHCF or its agent.

   c) Be in receipt of a service authorization that identified the hours for which the individual is eligible (PCA Service Authorization).

2) Payment shall be provided at an hourly rate established by DHCF. The unit of service is fifteen (15) minutes. Payment will be the reimbursed units determined by the service authorization and billed in accordance with the person-centered individual service plan (care plan). ~~Payment shall be provided at an hourly rate established by DHCF. Payment will be dictated by the amount, duration, and scope of services determined in accordance with the person's service authorization pursuant to the face-to-face assessment conducted by DHCF or its agent.~~

3) An individual or family member other than the person's spouse, a parent of a minor child, any other legally responsible relative, or court-appointed guardian may provide PCA services. Legally responsible relatives do not include parents of an adult child, so parents

of an adult child enrolled in the Waiver are not precluded from providing PCA services.

4) Other limitations include the following:

1. PCA services shall not include services that require the skills of a licensed professional, such as catheter insertion, procedures requiring the use of sterile techniques, and medication administration.

2. Shall not include tasks usually performed by chore workers or homemakers, such as cleaning of areas not occupied by the recipient, ~~laundry for family members,~~ and shopping for items not related to promoting the person's nutritional status and other health needs, and shopping for items not used by the person, or money management.

3. Shall not be provided in a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, or any other living arrangement which includes PCA services as a reimbursed service. However, persons residing in assisted living may receive services upon prior authorization by DHCF or its agent.

4. When a recipient is receiving PCA services and homemaker services from two different staff persons who are employees of the same agency, all supervisory registered nurse (RN) visits shall be coordinated so that supervisory in-home RN visits are made in accordance with waiver standards and the supervisory in-home RN visits are made by the same supervising RN at the same time.

5. When a person is receiving PCA and any adult day services (waiver or State Plan) on the same day, the combination of both PCA and adult day services shall not exceed a total of twelve (12) hours per day.

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

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

☑ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative (check relative)**

☐ **Legal Guardian**

Service Type: Statutory Service
Service Name: Personal Care Aide

Provider Category: Agency
Agency
Provider Type:
Home Care Agency
Provider Qualifications
License *(specify):*
Be a home care agency licensed pursuant to the requirements for home care agencies as set forth in the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code, §§ 44-501 *et seq*. (2005 Repl. & 2012 Supp.)), and implementing rules; and

Certificate *(specify):* N/A

Other Standard *(specify):*

1) Be enrolled as a Medicare home health agency qualified to offer skilled services as set forth in Sections 1861(o) and 1891(e) of the Social Security Act and 42 CFR § 484; and

2) Have a current Medicaid provider agreement on file with DHCF before providing any waiver services

3) All Personal Care Aides shall have the same qualification and standards as established under the Medicaid State Plan ~~as follows~~

~~(a) Be at least eighteen (18) years of age;~~

~~(b) Be a citizen of the United States or an alien who is lawfully authorized to work in the United States;~~

~~(c) Be mentally, physically and emotionally competent to provide services as certified by a physician;Be able to accept instruction from an R.N.;~~

~~(d) Be certified and meet all of the qualifications, including training requirements, in accordance with the Practice of Nursing Amendment Act of 2009, effective July 7, 2009 (D.C. Law 18-18; 56 DCR 3624), and 22-B DCMR§3915;~~

~~(e) Be certified in cardiopulmonary resuscitation (CPR) and maintain current CPR certification;~~

~~(f) Complete three (3) hours of continuing education at quarterly intervals, in addition to annual CPR recertification and be trained on the beneficiary's plan of care;~~

~~(g) Be able to read and write the English language at least at the fifth (5th) grade level and carry out instructions and directions in English;~~

~~(h) Be able to recognize an emergency and be knowledgeable about emergency procedures;~~

~~(i) Be knowledgeable about infection control procedures;~~

~~(j) Confirm on an annual basis that he or she is free from tuberculosis by undergoing an annual purified protein derivative (PPD) skin test;~~

~~(k) Confirm, on an annual basis, that he or she is free from communicable disease by undergoing an annual physical examination by a physician, and obtaining written and signed documentation from the examining physician confirming freedom from communicable disease;~~

~~(l) Pass a criminal background check pursuant to the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238; D.C. Official Code, §§ 44-551 *et seq*. (2005 Repl. & 2012 Supp.));~~

~~(m) Pass a reference check and a verification of prior employment;~~

~~(n) Provide documentation of acceptance or declination of the hepatitis vaccine; and~~

~~(o) Have an individual National Provider Identification (NPI) number obtained from NPPES~~.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure provider qualifications of Home care agency. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Frequency of Verification:

DHCF's Long Term Care Administration will verify initial reviews at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years).

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

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

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

- ☐ **Legally Responsible Person**
- ☑ **Relative (check relative)**
- ☐ **Legal Guardian**

7) Environmental Accessibility Adaptation Services

Service Type: Other Services

Service Title:

Environment Accessibility and Adaptation Services

Check this box:

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

Service Definition *(Scope):*

Those physical adaptations to the private residence of the person or the person's 's family, required by the person's service plan, that are necessary to ensure the health, welfare and safety of the person seeking EAA services or that enable the person to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars/hand-rails, widening of doorways, installation of lift systems, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the person enrolled in the Waiver.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

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

The maximum allowable cost per person seeking EAA services is $10,000. This rate is inclusive of a five hundred dollar ($500) reimbursement rate for the costs associated with the home inspection or evaluation. All service(s) required are subject to approval or denial by the State Agency prior to the provision of such service(s). This is a one-time service , limited to $10,000 per person over the duration of the waiver.

Both certified home-owners, and renters are eligible for EAA services. EAA services will only be approved or reimbursed for a certified home owner who can demonstrate that they are ineligible for the Handicap Accessibility Improvement Program (HAIP) administered by the DC Department of Housing and Community Development and the HAIP program. The case manager shall assist all eligible and certified home owners to apply for the HAIP program. If a home owner is denied participation in the program, the person seeking EAA services must provide a copy of the denial letter to the case manager.
In the case of rental property and/or leased property, no EAA services will be approved or reimbursed unless the following conditions are met: 1) the current rental and/or lease agreement, or residential agreement (and all other relevant documents) are thoroughly examined (by the case manager) to determine whether EAA services are prohibited or allowed with conditions, and (2) a signed release was obtained from the management of the property authorizing the EAA home modifications to be made.

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

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

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

- ☐ **Legally Responsible Person**
- ☑ **Relative (check relative)**
- ☐ **Legal Guardian**

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

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

Provider Category: Individual

Provider Type:
Certified Third Party Construction Inspector, Licensed Contractor, or Licensed Building Contractor.

Provide Qualifications

License *(specify):*
All Contractors shall be licensed by the Department of Consumer and Regulatory Affairs;

Certificate *(specify):*
Certified Third Party Construction Inspector shall be certified under the District of Columbia Department of Consumer and Regulatory Affairs, Third Party Inspector Program

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

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure provider qualifications of Home care agency. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Frequency of Verification:
DHCF's Long Term Care Administration will verify initial reviews at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years).

8) Assisted Living

Service Type: Other Service

Service Title:

Assisted Living

Check this box:

( ) **Service is included in the approved waiver. There is no change in service specifications**
(x) Service is included in approved waiver. The service specifications have been modified.
( ) Service is not included in the approved waiver.

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

As specified in DHCF's transition plan (see Amendment, Attachment #2, HCBS Transition Plan), DHCF's Long Term Care Administration (LTCA) is adopting a new EPD Provider Readiness Review Checklist which will be used to process renewals of assisted living providers' status as EPD Waiver providers and to verify compliance with the following requirements under 42 CFR 441.301:

(vii) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

(viii) The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

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

(x) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

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

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

(xiii) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

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

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

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

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

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

(xviii) Any modification of the additional conditions specified in §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(1) Identify a specific and individualized assessed need.
(2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
(3) Document less intrusive methods of meeting the need that have been tried but did not work.
(4) Include a clear description of the condition that is directly proportionate to the specific assessed need.
(5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.
(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
(7) Include the informed consent of the individual.
(8) Include an assurance that interventions and supports will cause no harm to the individual.

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

~~Assisted living services may be provided: (1) up to 28 hours a week when combined with home health aide services as long as the services are not received more than three days per week; (2) up to 35 hours a week when combined with home health aide services and the need is documented, as long as the services are not received more than four days per week; or (3) up to seven days when combined with home health aide services if the need is documented and the services are received temporarily, usually up to 21 days.~~

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

A provider will not be reimbursed for assisted living services if they do not meet the “setting” requirements under 42 CFR 441.301 as verified by the Provider screening and Readiness Review process.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative (check relative)**
- ☐ **Legal Guardian**

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living

Provider Category: Agency

Provider Type: Assisted Living Facility

Provider Qualifications

License *(specify):*
Facility must be licensed by the District of Columbia Health Regulation Administration
Staff RN and/or LPN must maintain current State license

Certificate *(specify):*
Copies of current license and certification of staff, Personal Care Aides.
Medication Technician, Homemaker

Other Standard *(specify):*
In compliance with Assisted Living Resident Regulatory Act of 2000

In compliance with Health Regulation Administration Home Care Agencies DC Municipal Regulations (DCMR)Title 22, Chapter 39.”

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

Verification of Provider Qualifications
Entity Responsible for Verification:

DHCF’s Long Term Care Administration will conduct an initial provider screening and readiness review to ensure provider qualifications of Home care agency. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services. District of Columbia, Department of Health, Health Regulation, and Licensing Administration is also responsible for verification of license.

Frequency of Verification:
DHCF’s Long Term Care Administration will verify initial reviews at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years).

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

9) Occupational Therapy Services

Service Type- Other

Check this box:

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

Service Title- Occupational Therapy Service

Service Definition *(Scope):*
Occupational Therapy services are designed to maximize independence, prevent further disability, and maintain health. These services should be provided in accordance with the person-centered ISP. All Occupational Therapy services should be monitored to determine which services are most appropriate to enhance the person's well-being and to meet the therapeutic goals. This is not an extended state plan service. This service may be used in addition to or in place of the state plan service if indicated as needed by the physician. This service differs from the state plan service by provider qualifications and locations where service may be delivered. The occupational therapist, under the HCBS waiver, is not restricted to those employed by home care agencies. This service may be delivered by any licensed practitioner and is delivered in the person's home or day service setting

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

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

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

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

- ☐ **Legally Responsible Person**
- ☑ **Relative (check relative)**
- ☐ **Legal Guardian**

Return to Summary of Services

Service Type: Other Service

Service Name: Occupational Therapy
Provider Category: Individual

Individual

Provider Type: Occupational

Occupational

Provider Qualifications

License *(specify):*
An Occupational Therapist licensed to practice occupational therapy in accordance with the requirements of Chapter 63 of Title 17 of the D.C.M.R; or

Be a home care agency licensed pursuant to the requirements for home care agencies as set forth in the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code, §§ 44-501 *et seq*. (2005 Repl. & 2012 Supp.)), and implementing rules; and

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure provider qualifications of Home care agency. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services. District of Columbia, Department of Health, Health Regulation, and Licensing Administration is also responsible for verification of license.

Frequency of Verification:
DHCF's Long Term Care Administration will verify initial reviews at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years).

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

10) Physical Therapy

Service Type- Other

Check this box:

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

Service Title- Physical Therapy Service

Service Definition

Physical Therapy (PT) services are designed to maximize independence, prevent further disability, and maintain health.

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

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

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

Provider Category: Individual

Individual

Provider Type: Physical Therapist or Physical Therapy Assistant working under the direct supervision

Provider Qualifications

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

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

Home Care agency
License-

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

Verification of Provider Qualifications
Entity Responsible for Verification:

DHCF's Long Term Care Administration will conduct an initial provider screening and readiness review to ensure provider qualifications of Home care agency. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services. District of Columbia, Department of Health, Health Regulation, and Licensing Administration is also responsible for verification of license.

Frequency of Verification:
DHCF's Long Term Care Administration will verify initial reviews at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-enrollment process (every three years).

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

11) Individual-Directed Goods and Services

Service Type: Other

Check this box:

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

Service Title:
Individual-Directed Goods and Services

Service Definition (Scope):
Services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the person-centered Individual Service Plan (ISP) (including improving and maintaining the individual's opportunities for full membership in the community) and meet the following requirements. The item or service would:

- decrease the need for other Medicaid services; and/or
- promote inclusion in the community; and/or
- increase the waiver participant's safety in the home environment.

Individual-directed goods and services are only available to waiver participants who are enrolled in the Services My Way program, which is the participant-directed services (PDS) program in the District of Columbia. Furthermore, individual-directed goods and services are only available if the individual does not have the funds to purchase the good or service or the good or service is not available through another source. Individual-directed goods and services are purchased from the participant's PDS budget. Experimental or prohibited treatments are excluded. Individual-directed goods and services must be documented in the participant's person-centered ISP and approved by the Services My Way Program Coordinator at DHCF.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Waiver participants who elect to enroll in the Services My Way program may purchase individual-directed goods and services that are included in their person-centered ISP, meet the criteria listed above and are within the means of their PDS budget to purchase. Support brokers will help participants revise their PDS budgets, as necessary, to account for new, appropriate individual-directed goods and services they would like to purchase and help them manage their PDS budgets.
Upon revising a PDS budget to reflect a new individual-directed good or service, the support broker will submit the revised PDS budget to the Services My Way Program Coordinator for approval. The Program Coordinator must approve any individual-directed good or service requested. Upon approval, the Services My Way Program Coordinator will submit the amended PDS budget to the Vendor Fiscal/Employer Agent (VF/EA) FMS-Support Broker entity, allowing the VF/EA FMS-Support Broker entity to authorize payment of vendor invoices submitted for the approved individual-directed goods and services.

Service Delivery Method (check each that applies):
Participant-directed as specified in Appendix E

Provider Specifications:

Service Type: Other Service

Service Name: Individual-Directed Goods and Services

Provider Category:
Individual

Provider Type:
Individual/vendor as selected by the participant

Provider Qualifications

License (specify):
Valid business license in good standing, if applicable.

Certificate (specify):
N/A

Other Standard (specify):
All individuals/vendors providing individual-directed goods and services must be at least 18 years of age. All individuals/vendors must be able to: (1) demonstrate to the waiver participant that they have the capacity to perform the requested work and the ability to successfully communicate with him/her; and (2) have all necessary professional and/or commercial licenses required by federal, state and local statutes and regulations, if applicable.

Individuals/vendors providing non-medical transportation as an individual-directed service must have: (1) a valid driving license and (2) the minimum amount of liability insurance required by the District of Columbia for the type of vehicle used to provide the transportation. Furthermore, if applicable, individuals/vendors shall enter into a Medicaid provider agreement, as required by CMS, which shall be executed by the VF/EA FMS-Support Broker entity on behalf of DHCF.

Verification of Provider Qualifications

Entity Responsible for Verification:
VF/EA FMS-Support Broker entity

Frequency of Verification:
At time of enrollment and thereafter as necessary.

12) Participant –Directed Community Support Services

Service Type: Other

Check this box:

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

Service Title:

Participant-Directed Community Support (PDCS)

Service Definition (Scope):
Participant-Directed Community Support (PDCS) is available to waiver participants enrolled in the Services My Way program as described in Appendix E. Services offered under PDCS are detailed in the participant's person-centered Individual Service Plan (ISP) and PDS budget and are designed to promote independence and ensure the health, welfare, and safety of the participant.
The participant or his/her designated representative, as applicable, is the common law employer of the participant-directed worker (PDW) providing services. These PDWs are recruited, selected, hired, and managed by the participant/representative-employer. As described in Appendix E, supports will be available to assist the participant/representative-employer with employer-related responsibilities through the VF/EA FMS-Support Broker entity.

Allowable Tasks: Services provided under participant-directed community support (PDCS) include the following: cueing or hands-on assistance with performance of routine activities including bathing, grooming, assistance with toileting, or bed pan use; changing urinary drainage bags; assisting participants with self-administered medications (a PDW may remind but cannot administer the medication to the participant); reading and recording temperature, pulse, and respiration; observing and documenting the participant's status and verbally reporting to the waiver case manager the findings immediately for emergency situations and within four (4) hours for other situations; accompanying the person to medically-related appointments or place of employment and recreational activities if approved in the participant's person-centered ISP and PDS budget; shopping for items to promote the participant's nutritional status and other health needs; recording and reporting to the waiver case manager any changes in the participant's physical condition, behavior, or appearance.

Tasks also include providing assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

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

The tasks performed under PDCS are similar to those performed by a personal care aide (PCA). However, PDCS is provided pursuant to a person's PDS budget and uses a different rate methodology as described in Appendix E. This waiver lifts any State Plan restrictions on the number of allowable hours of PDCS provided by a PDW as long as the hours in excess of State Plan limitations are provided in accordance with an approved person-centered ISP and PDS budget and are cost effective. Payment will not be made to a PDW who is the participant's (a) spouse or (b) parent or, if minor participant, legal guardian.

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

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

a) Be in receipt of a written order for PCA services, signed by a physician or Advanced Practice Nurse who: (1) enrolled in Medicaid and (2) has had a prior professional relationship with the participant that included an examination(s) provided in a hospital, primary care physician's office, nursing facility, or at the participant's home prior to the prescription of the personal care services;

b) Be unable to independently perform one or more activities of daily living for which personal care services are needed as established by the face-to face assessment conducted by DHCF or its agent; and

c) Be in receipt of a service authorization that identified the hours of PDCS services for which the individual is eligible.

2) Payment shall be provided in accordance with the participant's PDS budget and at an hourly wage within the wage range prescribed by DHCF. The hourly wage for a PDW shall be no less than the DC living wage and no more than the hourly wage paid to a PCA. Payment will be dictated by the amount, duration, and scope of services determined in accordance with the person's service authorization pursuant to the face-to-face assessment conducted by DHCF or its agent.

3) An individual or family member other than the person's spouse, a parent of a minor child, any other legally responsible relative, or court-appointed guardian may act as a PDW. Legally responsible relatives may not act as PDWs. Legally responsible relatives do not include parents of an adult child, so parents of an adult child participant are not precluded from providing PDCS services.

4) Other limitations on PDCS include the following:

   1. PDCS shall not include services that require the skills of a licensed professional, such as catheter insertion, procedures requiring the use of sterile techniques, and medication administration.

   2. PDCS shall not include tasks usually performed by chore workers, such as cleaning of areas not occupied by the participant, laundry for family members, shopping for items not used by the participant, or money management.

   3. PDCS shall not be provided in a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID) or institution for mental disease, or any other living arrangement which includes PCA services as a reimbursed service.

Service Delivery Method (check each that applies):
Participant-directed as specified in Appendix E

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

Provider Specifications:
Service Type: Other Service

Service Name: Participant-Directed Community Support

Provider Type:
Individual, Participant-Directed Worker

Provider Qualifications

License (specify):
N/A

Certificate (specify):
N/A

Other Standard (specify):

Participant-directed workers (PDWs) must meet the following qualifications:

a. Be at least eighteen (18) years of age;
b. Complete and pass a criminal background check pursuant to the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999, as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002, (D.C. Laws 12-238 and 14-98), D.C. Official Code § 44-551 et seq.;
c. Receive customized training provided by the participant and/or his/her authorized representative;
d. Be able and willing to provide the service-related responsibilities outlined in the participant's person-centered ISP; and
e. Be certified in cardiopulmonary resuscitation (CPR) and First Aid and maintain current certifications.

Verification of Provider Qualifications

Entity Responsible for Verification:
The participant or authorized representative if designated as the common law employer of PDWs, and the VF/EA FMS-Support Broker entity determining if PDW has met minimum qualifications.

Frequency of Verification:
At time of PDW recruitment prior to hire, and thereafter, once hired, as necessary. The VF/EA FMS-Support Broker entity will verify that PDW qualifications are met during the employment process and will execute a Medicaid provider agreement with each PDW on behalf of DHCF.

13) Case Management

Service Type: Statutory

Check this box:

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

Service Definition *(Scope):*
The conflict-free case management service is designed to ensure that the Medicaid beneficiary in need of long-term care services and supports (LTCSS) has opportunities to engage in community life, control personal resources, seek employment and work in competitive and integrated settings while receiving services in the community to the same degree as people who do not receive Medicaid funded services. The case manager is responsible for assessment, planning, linkage, monitoring, and advocacy relative to the particular needs of the person, where the resources necessary may be external (e.g., housing and education) or internal (e.g., identifying and developing skills). This includes assisting the person to access and maintain all public benefits to which they may be entitled.

The case manager's role is to support the person in developing a written comprehensive person-centered plan for Medicaid and non-Medicaid services (including community resources) that reflects the person's strengths, interests, preferences, community and family supports, personal goals, financial resources, and assessed needs. Based on this plan, the case manager develops an Individual Services Plan (ISP) and assists the person in accessing an individualized mix of services detailed in the ISP in the most integrated community setting appropriate to their needs and desires, and provides ongoing monitoring of the person's use of the services and supports detailed in the ISP.

Additionally, the case manager advocates on the person's behalf within service networks while ensuring the person accesses and stays connected to all public benefits for which they are eligible. Case managers do not replace family systems and/or other community services, but augment the person's natural supports.

I. Requirements for Person-Centered Planning

The case manager shall commit to making services fit persons, rather than making persons fit services, and enable a person-centered planning process, directed by the person with long-term services and support needs (or a representative they choose), that meets the following requirements:

(1) Occurs at a time and location that is convenient for the person and any other individuals that person wants included in the planning;
(2) Includes face-to-face discussions with the person whose plan is being developed, other contributors chosen and invited by the person, and representatives of the person's interdisciplinary team, as possible;
(3) Incorporates feedback of members of the person's interdisciplinary team and other key individuals if and when they are unable to participate in face to face discussions inclusive of the individual
(4) Ensures that information shared with the person is aligned to his or her acknowledged cultural preferences and communicated in a manner that ensures the person and/or his or her representative understands the information. Communication must be consistent with the policies/practices of the US Health and Human Services Office on Minority Health Standards National Standards on Culturally and Linguistically Appropriate Services (CLAS) http://www.minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15. If needed, auxiliary aids and services should be provided;
(5) Provides meaningful access to persons and/or their representatives with limited English proficiency (LEP), including low literacy materials and interpreters;
(6) Uses a strengths-based approach to identifying the positive attributes of the person, including an assessment of the person's strengths, preferences, and needs;
(7) Embraces the personal preferences of the individual to develop goals and to meet the person's needs;
(8) Explores employment and housing in integrated settings, where planning is consistent with the individual's goals and preferences, including where the individual resides and who they live with; and
(9) Ensures that persons under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, have the opportunity to address any concerns related to the person-centered Individual Service Planning process.

II. Development of the Person-Centered Individual Service Plan

The case manager shall ensure that the person-centered ISP highlights the person's strengths and that it aligns with the person's articulated quality of life goals, service and support needs, and preferences. Specifically, the person-centered ISP must:

(1) Document the person's strengths and positive attributes at the beginning of the plan;
(2) Document the goals of the person and/or representative in his or her own words, which tie to the specific amount, duration, and scope of services that will be provided;
(3) Document the person's preferences related to end of life planning;
(4) Be in a language and dialect and at the literacy level needed to be understandable for the individual and/or his or her representative;
(5) Specify the other contributors chosen and invited by the person to engage in the person-centered planning and in monitoring the execution of the ISP;
(6) Include consideration of and any resulting goals for employment, education and community participation;
(7) Identify necessary services and supports, to be provided through Medicaid and non-Medicaid services, including supports from the person's family, friends, faith-based entities, recreation centers, or other available community resources;
(8) Prevent duplicative, unnecessary or inappropriate services by identifying only the necessary services chosen by the person;
(9) Identify the specific persons and/or health care providers and/or other entities providing services and supports;

(10) Develop, in partnership with the person, a risk mitigation plan (along with a back-up emergency plan); the plan must consider the person's right to assume some level of responsibility for the identified risk and solutions to mitigate them;
(11) Assure the health and safety of the person;
(12) Document the following (if a person's needs related to health and safety warrants restrictions on the person's environment):

(a) The explicit and individualized assessed safety need;
(b) Positive interventions used in the past to address the same or similar safety risk;
(c) Explanation of the condition directly related to the specified safety need;
(d) Description of plan modifications addressing the safety risk, and the results of routine collection of data measuring the effectiveness of the modification;
(e) Documentation that the person and/or representative understands and consents to the proposed modification;
(f) Time limit determined to evaluate if safety modification is still necessary or can be terminated; and
(g) Assurance that the modification will not cause harm to the person.

(13) Address components of self-direction if the person has chosen a self-directed delivery system;
(14) Assure the person's needs will be addressed in the case of a District-wide emergency, such as a black-out or District-wide electronic system failure;
(15) Receive final approval and signature of the completed person-centered Individual Service Plan from those who participated in its planning and development, with mandatory signatures of the individual and the case manager.
(16) All contributors chosen and invited by the person to participate in the person-centered planning process must receive a copy of the completed ISP (or a

component of the plan, as determined by the individual).

III. Implementing and Monitoring the Person-Centered Individual Service Plan (ISP)

The case manager shall work with the person to implement the person-centered Individual Service Plan. Specifically, the case manager shall:

(1) Assist with initiating services and accessing community supports.

(2) Coordinate care across the various and multiple services and /or providers connected to the ISP, regardless of source of payment.

(3) Monitor the person to ensure that needs and preferences are being met and that the person receives services described in the ISP in type, scope, duration, and frequency. If results of routine monitoring activities necessitate updates to the ISP, this should be done within seven (7) days of said monitoring activity, with approval signatures from those who participated in ISP planning and development, with mandatory signatures of the individual and the case manager.

(4) Review and update the ISP at least every twelve months or when the person's functional needs change, circumstances change, quality of life goals change, or at the person's request.
  (a) The case manager must respond to personal requests for updates within forty-eight (48) hours, with completion of the update within seven (7) days.
  (b) The updated ISP must be done via face-to-face discussions with the person whose plan is being developed, other contributors chosen and invited by the person, and representatives of the person's interdisciplinary team, as possible.
  (c) The updated ISP must incorporate feedback of members of the person's interdisciplinary team and other key individuals if and when they are unable to participate in face to face discussions inclusive of the individual.
  (d) The updated ISP must include approval signatures from those who participated in ISP planning and development, with mandatory signatures of the individual and the case manager

(5) Assist in obtaining required documents for the initiation of and on-going maintenance of services (e.g., securing physician orders, etc.), particularly at the time of required renewals and recertification.

(6) Ensure quality of care and service provision, including identification and resolution of problems with providers and services identified in the ISP.

(7) Provide supportive counseling to the person and family, as appropriate.

(8) Maintain records to provide supportive documentation of all conflict-free case management services provided. All records must be maintained in a manner consistent with District of Columbia privacy and confidentiality rules.

(9) Ensure that Medicaid renewals and any required re-certifications are complete before the end of an individual's renewal or certification period, including ensuring the individual obtains annual level of care redetermination.

(10) Monitors implementation of ISP via monthly (at minimum) check-ins that are documented in DC's electronic case management system to ensure that persons are receiving services per the plan.

IV. Conflict Free Requirements

Case managers must be "conflict-free," and shall not:

(1) Be related by blood or marriage to the person, or to any paid caregiver of the person;
(2) Be financially responsible for the person, or be empowered to make financial or health decisions on the person's behalf;
(3) Hold financial interest, defined under 42 CFR 411.354, in any entity that is paid to provide care for the individual; and
(4) Be employed or under contract to a provider of a person's other direct program services under the EPD Waiver.

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

Included in this service unit are the following activities, related to general oversight of the person relative to their person-centered Individual Service Plan:

(1) Conducting monthly home visits, at minimum (which are not limited to within 30 days of the prior visit);

(2) Communicating and coordinating with the person whose plan is being developed, other contributors chosen and invited by the person, and representatives of the person's interdisciplinary team, as needed and possible;
(3) Communicating regularly with service providers as needed (e.g., providers of other EPD waiver services such as Personal Care Aide services and medical professionals such as gerontologists, etc.);
(4) Coordinate among other involved case managers or care coordinators (i.e., ADRC transition coordinators or lead agency social workers, etc.);
(5) Documenting all case management activities;
(6) Assisting the person to obtain level of care re-determination and Medicaid recertification, as needed;
(7) Communicating with State agency personnel, as needed; and
(8) Any other activities related to the efficient administration of the ISP.

The person and/or authorized representatives may elect to receive or not receive any waiver services by signing the "Beneficiary Freedom of Choice Form."

Note that service providers

- May not receive Medicaid reimbursement for case management services to ineligible persons or to Medicaid non-beneficiaries
- May not provide medical, financial, or legal services (except for referral to qualified individuals, agencies or program)

Case Management Agency
Provider Qualifications

License (specify):
Case management agencies are required to be enrolled as a provider in the District of Columbia Medicaid Program as case management agencies in the EPD waiver. Staff providing conflict-free case management services must have current appropriate licensure, and have a Masters and one year of experience with the population, with either a degree in Social work, Psychology, Counseling, Rehabilitation, Nursing, Gerontology, or sociology OR a Bachelors degree and the above current licensure and 2 years of experience with the population OR Registered Nurse [RN] can have an Associate Degree and 3 years of experience

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

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

Certificate *(specify):*

Other Standard *(specify):*

Social Service Agency and Community-Based Organization: By-laws or similar documents regulating conduct of providers' internal affairs; policies and procedure and QA Plan

Minimum standards

1. Each case manager must be an employee of a social service agency and/or other community-based organization hereafter known as the provider, enrolled as a Medicaid provider. Each case manager must perform case management duties either on a full-time basis (i.e., an employee working 0.75 FTE or greater) or on a part-time basis (i.e., an employee working from 0.5 to 0.74 FTE).
2. Each case manager must display accessibility (e.g., to individuals receiving EPD services; to District staff or designees; and to case management agencies, etc.) by acknowledging and responding to inquiries within 24 hours of receipt.
3. Each case manager must self-attest to meeting the CMS conflict-free standards in accordance with 42 CFR § 441.301 (c)(1)(vi), using the DHCF Conflict-Free Case Management Self-Attestation Form.
4. Each case manager will be assigned to no more than 50 individuals, depending on acuity of the persons receiving services, proficiency of the case manager, and level of support (e.g., from a case management assistant, etc.).
5. A case manager must not be an employee of a Home Health Agency or other EPD-waiver direct service provider.
6. Each case manager must demonstrate a service history and current capacity to assist persons in accessing services provided through the District government and/or through community services.
7. Each case management agency must demonstrate a comprehensive knowledge and understanding of the District of Columbia Medicaid program including knowledge of relevant community resources, limitation on State Plan services, and an understanding of the relationship between State Plan and waiver services where applicable.
8. Each case management agency must establish and implement a process by which the person has been informed of his/her freedom of choice rights, and that the person and/or the person's legal guardian has signed a "Waiver Beneficiary Freedom of Choice Form" indicating that he/she has elected to receive a home and community-based services. Services not provided in accordance with this standard will not be reimbursed
9. Each case management service provider must provide the person and/or the person's representative, family members and/or legal guardians with agency procedures for protecting confidentiality, for reviewing progress against the ISP, participant rights, and other matters germane to the individual's decision to accept services.

10. Each case manager is responsible for conducting a comprehensive intake assessment of the person within forty-eight (48) hours of receiving the waiver request and prior to the development of the ISP. The intake assessment findings and ISP must be completed within seven (7) working days of conducting the assessment.
11. Each case manager must include other contributors chosen and invited by the person, and representatives of the person’s interdisciplinary team, as possible, to participate in the initial assessment and the development and implementation of the approved person-centered Individual Service Plan, as per participant request and/or as appropriate.
12. Development of the ISP must include the person whose plan is being developed, other contributors chosen and invited by the person, and representatives of the person’s interdisciplinary team, as possible.
13. It is the responsibility of the case manager to ensure the ISP is provided to the State Agency (or its designee) for approval of services. The State Agency (or its designee) will approve or disapprove the ISP within seven (7) working days of its receipt.
14. Each case manager must complete and provide to each case management agency for whom he or she works the DHCF Conflict-Free Case management Self-Attestation form.
15. Each case manager must ensure the person is given free choice of all qualified Medicaid providers of each service included in his/her written person-centered Individual Service Plan.
16. Each case manager must provide the person, the person’s representative, family members and/or legal guardians with information on how other needed services (e.g., Medicare, SSI, transit, housing, legal assistance, energy assistance, etc.) may be obtained.
17. All case managers must demonstrate comprehensive knowledge of and actual experience with assisting persons to access all types of community-based programs including legal services, rent assistance programs, food and nutrition programs (including Supplemental Nutrition Assistance Program/SNAP), cash benefit programs (including SSI) and energy assistance programs.
18. As part of on-going monitoring of the person’s person-centered Individual Service Plan, each case manager is required to make an in-home visit to the person at a minimum of at least once per month and more frequently as required by the person’s needs. Supplemental telephone contacts may be made as required by the individual needs of the person receiving services.
19. Case managers must provide services in accordance with provider guidelines and any amendments developed by the State Agency.
20. Each case manager is required to assist the person in accessing all necessary services noted in the person-centered Individual Service Plan, whether they are Medicaid (State Plan) services, Medicaid (Waiver) services and/or non-Medicaid financed services.
21. Each case manager is required to take training by the State Agency (as scheduled and required by the State Agency) in order to promote the efficient and effective delivery of Medicaid-financed services.
22. Each case manager must develop and implement a plan to ensure against duplication of services being provided to the person.
23. The qualifications for a case manager are specified in Chapter 42 of Title 29, 4216.2 (a-c) of the District of Columbia Municipal Regulations (DCMR) entitled, Home and Community-Based Waiver Services for Persons who are Elderly and Individuals with Physical Disabilities,” and read as follows:

“An individual conducting case management services shall meet one of the following requirements:”

1. Have a current appropriate licensure, and have a Master’s degree in social work, psychology, counseling, rehabilitation, nursing, gerontology, or sociology and have at least one (1) year of experience working with the elderly or individuals with physical disabilities;
2. Have a current appropriate licensure and have a Bachelor’s degree in social work, psychology, counseling, rehabilitation, nursing, gerontology, or sociology and have two (2) years of experience working with the elderly or individuals with physical disabilities; or
3. Have a current licensure as a Registered Nurse (RN), and have an Associate degree in nursing and at least three (3) years of experience working with elderly and individuals with physical disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCF Division of Long Term Care and DHCF Office of Program Operations

Frequency of Verification:

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

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