1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. **Services.** *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

   Adult Day Health Program (ADHP) Services

2. **Concurrent Operation with Other Programs.** (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

   ***Select one*:**

○	**Not applicable**
✓	**Applicable**

Check the applicable authority or authorities:

☑	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.* The state contracts with one health plan which furnishes services under the provisions of §1915(a)(1) which serves all geographic areas in the District. Capitated monthly payments are made to the health plan which furnish Adult Day Health Program Services. The 1915(a) contract has been submitted to CMS for review on October 1, 2021.
☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*

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

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)

☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*
☐	**A program authorized under §1115 of the Act.** *Specify the program*:

3. **State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** *(Select one)*:

✓	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	○	The Medical Assistance Unit *(name of unit)*:	
	✓	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	Long Term Care Administration
○	The State plan HCBS benefit is operated by *(name of agency)*		
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☑	☐
2 Eligibility evaluation	☑	☑	☑	☐
3 Review of participant service plans	☑	☐	☑	☐
4 Prior authorization of State plan HCBS	☑	☐	☑	☐
5 Utilization management	☑	☐	☑	☐
6 Qualified provider enrollment	☑	☐	☑	☐
7 Execution of Medicaid provider agreement	☑	☐	☑	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☑	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☑	☐
10 Quality assurance and quality improvement activities	☑	☐	☑	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Function (2) eligibility evaluation is a multi-step process for fee-for-service Medicaid enrollees. Once the Department of Health Care Finance's (DHCF's) Long Term Care Services and Supports (LTCSS) Contractor has completed the face-to-face assessment, the findings are released in DC Care Connect to the DCAging and Disability Resource Center (ADRC), which performs its responsibilities in accordance with its interagency agreement with DHCF. ADRC is a governmental agency within the District of Columbia Department of Aging and Community Living. ADRC is not a provider of 1915(i) services.

Function (3), review of person-centered service plan/authorization, is performed by the Quality Improvement Organization (QIO). The QIO reviews the PCSP to ensure that the goals and services are appropriate, approves the PCSP, and generates authorizations to ensure that the providers of the included services are able to submit claims for reimbursement.

Functions (1), (2), (3), (4), (5), (6), (7), (8), (9), and (10), are performed by the health plan(s) under DHCF's monitoring and oversight. For functions (1), (2), (6), (7), (8), (9), and (10) the health plan(s) will adhere to requirements established in the Medicaid contract for the Dual Eligible Special Needs Plan(s) authorizing and reimbursing for 1915(i) services under that contract. For function (9), the Contractor shall establish policies and procedures that define the requirements of Enrollee Individualized Care Plans.

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	April 1, 2020	March 31, 2021	177
Year 2	April 1, 2021	March 31, 2022	
Year 3	April 1, 2022	March 31, 2023	
Year 4	April 1, 2023	March 31, 2024	
Year 5	April 1, 2024	March 31, 2025	

2. ☑ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☐ The State does not provide State plan HCBS to the medically needy.

☑ The State provides State plan HCBS to the medically needy. (*Select one*):

☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☑ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

O	Directly by the Medicaid agency
✓	By Other (*specify State agency or entity under contract with the State Medicaid agency*):
	The DC Aging and Disability Resource Center (ADRC) is a governmental agency within the District of Columbia Department of Aging and Community Living. ADRC performs evaluations/ reevaluations of eligibility for State Plan HCBS in accordance with its interagency agreement with DHCF. For enrollees in a Dual Eligible Special Needs Plan, DHCF performs evaluations/reevaluations of eligibility for State Plan HCBS.. For D-SNP enrollees, the assessment/reassessment determinations are then reported to DHCF to support evaluations/reevaluations of eligibility.

2. **Qualifications of Individuals Performing Evaluation/Reevaluation**. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

ADRC staff performing ADHP evaluations/reevaluations for fee-for-service Medicaid enrollees must meet the minimum requirement. The minimum requirement for conducting evaluations/reevaluations is a degree in social sciences or a related field. Case management experience in the developmental disabilities field or a related field may be substituted for education on a year-for-year basis.

DHCF staff performing ADHP evaluations/reevaluations for Dual Eligible Special Needs Plan enrollees must meet the minimum requirement. The minimum requirement for conducting evaluations/reevaluations is a degree in social sciences or a related field. Case management experience in the developmental disabilities field or a related field may be substituted for education on a year-for-year basis.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

For fee-for-service Medicaid enrollees, the beneficiary first must get an LTCSS Prescription Order Form (POF) signed by an enrolled Medicaid provider (MD or APRN), which identifies the age of the individual as well as any diagnosed chronic medical conditions. To initiate the LTCSS face-to-face assessment process, the signed POF is sent directly to DHCF's LTCSS Contractor or uploaded into DC Care Connect. Upon receipt of the POF, DHCF's LTCSS Contractor schedules and then conducts the face-to-face assessment of the beneficiary's need for LTCSS using a standardized assessment tool that has been designed and validated for all long-term care populations. The needs-based criteria for the State Plan HCBS benefit, including ADHP services, is developed and determined by DHCF. Assessments and reassessments will be conducted in-person by an RN or LICSWemployed/contracted by DHCF's LTCSS Contractor or the contracted health plan. The assessment identifies a beneficiary's needs across multiple domains, including functional, clinical, and behavioral; the result indicates whether the individual meets the needs-based eligibility criteria for the 1915(i) HCBS benefit.

Once DHCF's LTCSS Contractor has completed the assessment, the findings are immediately available to ADRC in DC Care Connect. ADRC then evaluates information in DC Care Connect and determines whether the individual is eligible for the 1915(i) State Plan HCBS benefit.

For D-SNP enrollees, the contracted health plan conducts an assessment and reports the resulting information to DHCF for a determination of State Plan HCBS eligibility.

The reevaluation process does not differ from the initial evaluation process. If any individual is found not to meet the eligibility criteria, the individual has the right to appeal, request a reconsideration and/or fair hearing.

4. ☑ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

To be eligible for 1915(i) ADHP services, an individual has to obtain a minimum score of four (4) according to the District's assessment algorithm.

The needs-based criteria are determined by a standardized assessment tool which evaluates the individual's care and support needs across three domains: (1) functional; (2) skilled care; and (3) cognitive/behavioral.

1) Functional - Type and frequency of assistance required with activities of daily living such as bathing, dressing, eating/feeding, eating/feeding, transferring, mobility, and toileting.
2) Skilled Care – Occurrence and frequency of certain treatments/procedures, skilled care (e.g. wound care, infusions), medical visits, and other types of formal care.
3) Cognitive/Behavioral – Presence of and frequency with which certain conditions and behaviors occur (e.g., communications impairments, hallucinations or delusions, physical/verbal behavioral symptoms, eloping or wandering).

Completion of the assessment will yield a determination based on the results from the three domains.

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)

To be eligible for reimbursement of 1915(i) ADHP services, an individual has to obtain a minimum score of four (4) according to the District's assessment algorithm.. The needs-based criteria are determined by a standardized assessment tool which will include an assessment of the individual's support needs across three domains including: (1) functional; (2) skilled care; and (3) cognitive/behavioral. 1) Functional - Type and frequency of assistance required with activities of daily living such as bathing, dressing, eating/feeding, eating/feeding, transferring, mobility, and toileting. 2) Skilled Care – Occurrence and frequency of certain treatments/procedures, skilled care (e.g. wound care, infusions), medical visits, and other types of formal care. 3) Cognitive/Behavioral – Presence of and frequency with which certain conditions and behaviors occur (e.g., communications impairments, hallucinations or delusions, physical/verbal	An individual shall be eligible for nursing facility services if they obtain a higher total score (nine (9) or more according to the District's scoring and algorithm) on the assessment tool. For fee-for-service enrollees, nursing facility level of care is determined using the same standardized assessment tool that is used to determine state plan HCBS 1915(i) eligibility. For all enrollees, the same domains are evaluated and used to assess needs-based eligibility.	Individuals who qualify for ICF/MR services will not be assessed via DHCF's LTCSS assessment tool. To determine if an individual requires services furnished by an ICF/MR, assessments are conducted by DHCF's Quality Improvement Organization (QIO) via the DC Level of Need (LON) which is a comprehensive assessment tool to determine the level of care criteria for ICF/MR services. A person shall meet a level of care determination if one of the following criteria has been met: (a) The person's primary disability is an intellectual disability (ID) with an intelligence quotient (IQ) of fifty-nine (59) or less; (b) The person's primary disability is an ID with an IQ of sixty (60) to sixty nine	Individuals who are admitted to the hospital are considered acute care patients. There is no applicable waiver for individuals who meet a hospital LOC. The State Medicaid Agency (SMA) contracts with a Quality Improvement Organization (QIO), Qualis Health, to prior authorize hospital admissions for Medicaid beneficiaries who are in need of inpatient hospital services based on medical necessity criteria. There no applicable LOC or corresponding admission criteria for long term care or chronic care hospitalizations.

behavioral symptoms, eloping or wandering). Completion of the assessment will yield a final determination based on the results from the three domains.		(69) and the person has at least one (1) of the following medical conditions: (1) Mobility deficits; (2) Sensory deficits; (3) Chronic health problems; (4) Behavior problems; (5) Autism; (6) Cerebral Palsy; (7) Epilepsy; or (8) Spina Bifida. (c) The person's primary disability is an ID with an IQ of sixty (60) to sixty-nine (69) and the person has severe functional limitations in at least three of the following major life activities: (1) Self-care; (2) Understanding and use of language; (3) Functional academics; (4) Social Skills; (5) Mobility; (6) Self-direction; (7) Capacity for independent living; or	

		(8) Health and Safety. (d) The person has an ID, has severe functional limitations in at least three (3) of the major life activities set forth in (c) (1) through (c)(8) (see above); and has one (1) of the following diagnoses: (1) Autism; (2) Cerebral Palsy; (3) Prader Willi; or (4) Spina Bifida	

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

Individuals enrolled in the 1915(i) benefit shall:

(1) Be age 55 or older; and

(2) Have one or more chronic conditions or progressive illnesses as diagnosed by a physician

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: 1	
ii.	**Frequency of services**. The state requires (select one):	
	✓	**The provision of 1915(i) services at least monthly**
	○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

   (Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The District assures that this SPA will be subject to any provisions or requirements included in the District's mostrecent and/or approved home and community-based settings Statewide Transition Plan. The District will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

   DHCF's LTCSS Contractor or contracted health plan will perform face-to-face assessments to determine eligibility for all LTCSS programs. In particular, the initial face-to-face assessment will assess the participant's level of need for all LTCSS, including State Plan HCBS benefit, by using a standardized assessment tool. The LTCSS contractor or contracted health plan will also perform reassessments at least once every twelve (12) month period, or whenever there is a significant change to the person's health or service needs. The LTCSS contractor or contracted health plan are not/cannot be providers of state plan HCBS.

   The face-to-face assessment will be performed by an RN or LICSW employed by DHCF's LTCSS Contractor or contracted health plan. The staff performing the assessment will be licensed health care professionals trained in assessment of individuals with physical, cognitive, or mental conditions that trigger a potential for HCBS services and supports. Each RN and LICSW will be licensed or authorized to practice pursuant to qualifications prescribed by the District of Columbia Department of Health, Health Occupation and Regulations Act.

5. **Responsibility for Development of Person-Centered Service Plan**. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

The Aging, Disability, and Resource Center (ADRC), through an MOU with DHCF, will be responsible for developing the person-centered service plan (PCSP) for fee-for-service Medicaid enrollees. The contracted D-SNP will be responsible for developing the person-centered service plan for D-SNP enrollees and incorporating the PCSP into the beneficiary's Individualized Care Plan (ICP). The contracted D-SNP are not/cannot be providers of state plan HCBS. All person-centered service plans will be developed in consultation with the beneficiary, the beneficiary's guardian or representative, and any other person(s) chosen by the individual. Staff and agents performing person-centered service planning are licensed social workers employed by ADRC or the contracted health plan. The staff completing the PCSPs also must have intake, assessment, and options counseling experience, have completed person-centered thinking (PCT) trainings, have current knowledge of available resources, services options and providers, and be knowledgeable regarding best practices to improve health and quality of life outcomes.

6. **Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The person-centered service plan shall be based on a person-centered planning approach. The person-centered planning process shall be directed by the individual with long-term support needs and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process. The minimum requirements of the person-centered planning process are that the process results in a person-centered service plan with individually identified goals and preferences, including those related to community participation, health care and wellness, education, and others. The plan will reflect the services and supports to be received, and who provides them. The planning process, and the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare.

During the person-centered planning process, each person and their representative shall receive information regarding all services and supports for which they are eligible based upon the results of the face-to-face assessment. Once they have made a choice of service type, they will receive information regarding qualified providers. Trained staff, who are experienced in providing options counseling will assist persons to make an informed choice based upon his/her needs and preferences. All information will be presented in simple and easily understood English and individuals with limited English proficiency will receive services that are culturally and linguistically appropriate. Additionally, persons with disabilities will be provided with alternative formats and other assistance to ensure equal access.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

Each beneficiary is given a choice of 1915(i) ADHP providers from which to select. This information is provided by the contracted health plan for D-SNP enrollees or, for fee-for-service Medicaid enrollees, a licensed social worker at the ADRC during the intake and assessment process, PCSP development process, and via informational materials on the 1915(i) benefit /program. Additional information on the 1915(i) benefit and a District ADHP provider directory are both available on DHCF's Long Term Care Administration website.

Once the beneficiary has selected an ADHP provider, based on the information and guidance provided by the contracted health plan or ADRC, and has a completed PCSP, they will work with the ADHP provider to develop a written plan of care. The designated staff at the ADHP provider will have primary responsibility for developing a written plan of care to implement each person's PCSP.

In this way, participants will exercise their freedom of choice as it relates to which providers and professionals from whom they obtain ADHP services and supports. If additional options counseling is needed or desired, the beneficiary may be referred back to the contracted health plan or the ADRC for information regarding available services and to obtain information about qualified providers. Contracted health plan care management teams and the ADRC staff offer options counseling to persons who desire assistance to select or change qualified providers.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

The SMA or its designee will review each person-centered service plan as part of their administrative authority and contractual oversight. Once the person-centered service plan has been completed for fee-for-service Medicaid enrollees, the QIO reviews and approves it using the District's electronic case management system. Following approval, the QIO creates a service authorization.

9. **Maintenance of Person-Centered Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☑	Operating agency	☐	Case manager
☑	Other (*specify*):	Service providers			

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Adult Day Health Services Program (ADHP)

Service Definition (Scope):

ADHPs provide essential services including social service supports, therapeutic activities meals, medication administration, and transportation to therapeutic activities for adults, age fifty-five (55) and over, during the day, in a safe community setting outside of his or her home. Each community setting will be enrolled as a Medicaid provider of ADHP services.

Adult day health includes the following services: medical and nursing consultation services including health counseling to improve the health, safety and psycho-social needs of participants; 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 individual'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), consistent with District regulations, including administration of medication and/or assistance in self administration of medication as appropriate. Participants will also be provided with nutrition and meal services consisting of nutritional education, training, and counseling to participants and their families, and provision of meals and snackswhile in attendance at the ADHP setting; however, meals provided as part of these services shall not constitute a full nutritional regimen (3 meals a day). All services will be paid for through bundled per-diem rates.

Each participant will receive services based upon their strength, preferences and health care needs as reflected by their level of need and person-centered plan. Once an applicant requests the receipt of LTCSS, the contracted health plan in which the beneficiary is enrolled or, for fee-for-service Medicaid enrollees, DHCF's LTCSS Contractor, will conduct a face-to-face assessment of the individuals physical, cognitive, and behavioral health care and support needs, strengths and preferences, available service and housing options and availability of unpaid caregiver support to determine the individual's need for long-term services and supports. The assessment process uses a standardized assessment and results identify the individual's level of need. Recognizing that some participants may have more complex needs (such as a greater need forsupervision or support), DHCF has developed two reimbursement rates – one for those who meet the threshold eligibility criteria based upon their assessed needs (Acuity level 1) and theother for those whose assessed needs are higher (Acuity level 2). The enhanced rates recognize that staffing levels must increase when participants have higher acuity levels.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits)*:
	N/A
☑	Medically needy *(specify limits)*:
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Adult Day Health Program	ADHP providers are not a licensed provider type;		Approved Provider Application

	they are certified in accordance with District regulations (see response under Certification).		Each ADHP provider shall meet the following criteria set by the SMA: (1) Enrolled as an ADHP Medicaid provider and maintains an approved, current Medicaid Provider Agreement; (2) Issued a valid Certificate of Need (CON) by the District of Columbia State Health Planning and Development Agency (SHPDA). (3) Successful completion of the SMA's Provider Readiness Review process, which ensures that the following are in place: (a) A service delivery plan to render delivery of ADHP services; (b) A staffing and personnel training plan in accordance with any SMA requirement; and; (c) Policies and procedures in accordance with any requirements set by the SMA. Each ADHP shall maintain minimum insurance coverage as follows: (1) Blanket malpractice insurance for all employees in the amount of at least one million dollars ($1,000,000) per incident; (2) General liability insurance covering personal property damages, bodily injury, libel and slander of at

			least one million ($1,000,000) per occurrence; and (3) Product liability insurance, when applicable

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Adult Day Health Program	The District's SMA (Department of Health Care Finance)	Initially and at least every two years

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

2. ☐ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. **Election of Participant-Direction**. (S*elect one):*

✓	The state does not offer opportunity for participant-direction of State plan HCBS.
O	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
O	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. **Description of Participant-Direction. (Provide an overview of the opportunities for participant-**direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):

3. **Limited Implementation of Participant-Direction**. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

O	Participant direction is available in all geographic areas in which State plan HCBS are available.
O	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. **Participant-Directed Services**. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. **Financial Management.** (*Select one)* :

☐	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
☐	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. **Opportunities for Participant-Direction**

a. **Participant–Employer Authority** (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

✓	The state does not offer opportunity for participant-employer authority.	
O	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. **Participant–Budget Authority** (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

✓	The state does not offer opportunity for participants to direct a budget.
O	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans (a) address assessed needs of 1915(i) participants; (b) are updated annually; and (c) document choice of services and providers.**

2. **Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**

3. **Providers meet required qualifications.**

4. **Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**

5. **The SMA retains authority and responsibility for program operations and oversight.**

6. **The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**

7. **The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, unexplained deaths ,and exploitation, including the use of restraints.**

8. **The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	Service plans address assessed needs of enrolled participants
Discovery	
Discovery Evidence *(Performance Measure)*	**PM.1** Number and percent of ADHP participants who have service plans that address his/her assessed needs, including the health and safety risks. *Numerator: Number of* Person-Centered Service Plans (PCSP) *that address health and safety risks.* *Denominator: Number of* Person-Centered Service Plans (PCSP) reviewed.

		PM. 2 Individuals receive services described in their Person-Centered Service Plan. *Numerator: Number of individuals receiving services as described in their Person-Centered Service Plan.* *Denominator: Number of individuals required to have a prescribed Person-Centered Service Plans.* **PM. 3.** Percentage of assessed eligible individuals enrolled in a 1915(i) State Plan ADHP. *Numerator: Number of individuals enrolled in a 1915(i) State Plan ADHP* *Denominator: Number of assessed individuals meeting eligibility requirements for 1915(i) State Plan ADHP.*
	Discovery Activity *(Source of Data & sample size)*	Person-Centered Service Plans (PCSP) Universe reviewed no sampling done
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Provider; D-SNP
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	Service plans are updated annually
Discovery	
Discovery Evidence *(Performance Measure)*	PM 4. PCSPs updated at least annually *Numerator: Percentage of PCSPs updated at least annually.* *Denominator: Number of PCSPs due*
Discovery Activity *(Source of Data & sample size)*	Person-Centered Service Plans (PCSP) Universe reviewed no sampling done
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Provider; D-SNP
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	Service plans document choice of services and providers
Discovery	
Discovery Evidence *(Performance Measure)*	PM 1. Service Plans document choice of services and providers *Numerator: Number of new ADHP participants whose records have a signed freedom of choice form* *Denominator: Number of new ADHP Participants reviewed*
Discovery Activity *(Source of Data & sample size)*	Freedom of choice form Universe reviewed no sampling done

	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA
	Frequency *(of Analysis and Aggregation)*	Annually
Requirement		Eligibility Requirements: an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future
Discovery		
	Discovery Evidence *(Performance Measure)*	PM 1. An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future *Numerator: Number of new applicants that received and assessment for ADHP* *Denominator: Number of new applicants*
	Discovery Activity *(Source of Data & sample size)*	DC Care Connect (SMA case management system); Required D-SNP reporting to SMA Universe reviewed no sampling done
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
	Frequency	Quarterly
Remediation		

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA
	Frequency *(of Analysis and Aggregation)*	Annually
Requirement		Eligibility Requirements: The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately
Discovery		
	Discovery Evidence *(Performance Measure)*	PM 1. The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately *Numerator: Number of beneficiaries' initial determinations made in accord with written policies and procedures established for the contractor by the state Agency* *Denominator: Number of initial assessments completed*
	Discovery Activity *(Source of Data & sample size)*	DC Care Connect (SMA case management system); Required D-SNP reporting to SMA Universe reviewed no sampling done
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	SMA

	timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Annually
Requirement		Eligibility Requirements: The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS
Discovery		
	Discovery Evidence *(Performance Measure)*	PM 1. The 1915(i)-benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS *Numerator: Number of beneficiaries that received a reassessment at least annually* *Denominator: Number of beneficiaries enrolled*
	Discovery Activity *(Source of Data & sample size)*	DC Care Connect (SMA case management system); Required D-SNP reporting to SMA Universe reviewed no sampling done
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA
	Frequency *(of Analysis and Aggregation)*	Annually
Requirement		Providers meet required qualifications.
Discovery		
	Discovery Evidence	**PM. 1** Licensed clinicians meet initial licensure requirements.

	(Performance Measure)	*Numerator: Number of licensed clinicians with appropriate credentials.* *Denominator: Number of licensed clinicians eligible to provide services.* **PM. 2** Licensed clinicians continue to meet applicable licensure requirements under the District of Columbia, Department of Health's, Health Occupation and Revision Act of 2009, promulgated by the Department of Health's Occupational and Licensing Administration. *Numerator: Number of licensed clinicians with appropriate credentials.* *Denominator: Number of licensed clinicians required to be certified.*
	Discovery Activity *(Source of Data & sample size)*	Training Records; Required D-SNP reporting to SMA Universe reviewed no sampling done
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Provider
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA
	Frequency *(of Analysis and Aggregation)*	Annually
Requirement		Providers meet required qualifications.
Discovery		
	Discovery Evidence	**PM. 3** Provider agencies continue to meet applicable certification standards.

	(Performance Measure)	*Numerator: Number of providers that continue to meet applicable certification standards.* *Denominator: Number of providers subject to certification.*
	Discovery Activity *(Source of Data & sample size)*	Findings from monitoring tools; Required D-SNP reporting to SMA
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA Universe reviewed no sampling done
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA
	Frequency *(of Analysis and Aggregation)*	Annually
Requirement		Providers meet required qualifications.
Discovery		
	Discovery Evidence *(Performance Measure)*	**PM. 4** Staff receives orientation within 30 days of hire. *Numerator: Number of new staffs trained within 30 days of hire.* *Denominator: Number of new staffs.* **PM. 5** Staff receive ongoing training according to requirements outlined in program rules. *Numerator: Number of staffs trained according to requirements.* *Denominator: Number of staffs required to be trained.*

	Discovery Activity *(Source of Data & sample size)*	Training Records; Required D-SNP reporting to SMA Universe reviewed no sampling done
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA
	Frequency *(of Analysis and Aggregation)*	Annually
Requirement		Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2)
Discovery		
	Discovery Evidence *(Performance Measure)*	**PM1.** Individuals receiving Adult Day Health Program services reside in settings that comply with requirements outlined in 42 CFR 441.710 *Numerator: No. of residential settings meeting requirements outlined in federal rules* *Denominator: Total number of residential settings reviewed to determine compliance*
	Discovery Activity *(Source of Data & sample size)*	Provider Reports; Required D-SNP reporting to SMA Universe reviewed no sampling done
	Monitoring Responsibilities	SMA

	(Agency or entity that conducts discovery activities)	
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA
	Frequency *(of Analysis and Aggregation)*	Annually
Requirement		The SMA retains authority and responsibility for program operations and oversight
Discovery		
	Discovery Evidence *(Performance Measure)*	**PM1.** Individuals receiving Adult Day Health Program services reside in settings that comply with requirements outlined in 42 CFR 441.710 *Numerator: No. of residential settings meeting requirements outlined in federal rules* *Denominator: Total number of residential settings reviewed to determine compliance*
	Discovery Activity *(Source of Data & sample size)*	Provider Reports; Required D-SNP reporting to SMA Universe reviewed no sampling done
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities	SMA

	(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Annually
Discovery		
	Discovery Evidence *(Performance Measure)*	**PM2.** Adult Day Health services are delivered in settings that comply with requirements outlined in 42 CFR 441.710 *Numerator: No. of day settings meeting requirements outlined in federal rules* *Denominator: Total number of Adult Day health settings reviewed to determine compliance* **PM3.** Participants receiving Adult Day Health Services reside in settings that comply with requirements outlined in 42 CFR 441.710 per the Provider Readiness Review process *Numerator: Number of participants' residential settings that comply with the federal requirements per the Prospective Provider Application Tool* *Denominator: Total number of participant residential settings assessed via the Prospective Provider Application Tool*
	Discovery Activity *(Source of Data & sample size)*	Provider Readiness Review Data Universe reviewed no sampling done
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
	Frequency	Initially
Remediation		
	Remediation Responsibilities	SMA

	(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Annually
Requirement		The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers
Discovery		
	Discovery Evidence *(Performance Measure)*	**PM. 1** Percentage of prior authorizations issued timely. *Numerator: Number of prior authorizations issued within required time frame.* *Denominator: Number of prior authorizations issued by provider.* **PM. 2** Percentage of claims paid timely. *Numerator: Number of claims paid according to requirement.* *Denominator: Number of claims submitted for payment.* **PM. 3** Claims are paid in accordance with 1915(i) services rendered by 1915(i) providers. *Numerator: Number of claims paid according to requirement.* *Denominator: Number of claims submitted for payment.* **PM. 4** Claims are reviewed by Program Integrity audits that fail audit standards. *Numerator: Number of audited claims that fail audit standards.* *Denominator: Number of claims selected monthly for auditing.*
	Discovery Activity	MMIS – Claims Data; Required D-SNP reporting to SMA Universe reviewed no sampling done

	(Source of Data & sample size)	
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA
	Frequency *(of Analysis and Aggregation)*	Quarterly
Requirement		The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints and unexplained deaths.
Discovery		
	Discovery Evidence *(Performance Measure)*	**PM. 1** Incidents are reported within 24 hours or the next business day. *Numerator: Number of incidents related to abuse, neglect and exploitation, including unexplained deaths.* *Denominator: Number of incidents reported within 24 hours.* **PM. 2** Allegations of abuse, neglect, and exploitation incidents are investigated by provider. *Numerator: Number of incidents related to allegation of abuse, neglect and exploitation, including unexplained deaths.* *Denominator: Number of allegations of abuse, neglect incidents investigated.*
	Discovery Activity *(Source of Data & sample size)*	Incident Reports; Required D-SNP reporting to SMA Universe reviewed no sampling done

	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Provider
	Frequency	Monthly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA; Required D-SNP reporting to SMA Each ADHP shall notify the DHCF within twenty-four (24) hours from the date of their knowledge, in writing in the event of the death of a participant at, en route to, or en route from, the program site. In the event where death occurs as a result of possible abuse, neglect, or exploitation, ADHP providers are also required to report the incident to District of Columbia, Adult Protective Services (APS). All serious incidents involving a death which occurs at a program site are reported by the provider to the District of Columbia, Metropolitan Police Department (MPD). DHCF reviews incident reports and conducts on-site monitoring (annually and as needed) to ensure compliance with program requirements. An ADHP that fails to maintain compliance with the programmatic requirements may be subject to alternative sanctions (denial of payment, directed plan of correction, directed in-service training, and/or enhanced state monitoring) and/or termination of its participation in the Medicaid program.
	Frequency *(of Analysis and Aggregation)*	Quarterly
Requirement		The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider.
Discovery		
	Discovery Evidence *(Performance Measure)*	**PM.1** Percentage of beneficiaries that received an annual preventive health visit. *Numerator: Number of beneficiaries who received an annual preventive health visit.* *Denominator: Number of beneficiaries who were due for a preventive health visit.*
	Discovery Activity *(Source of Data & sample size)*	MMIS --Claims data 100% review
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA

	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA; Required D-SNP reporting to SMA
	Frequency *(of Analysis and Aggregation)*	Quarterly

System Improvement
(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

- The provider will be required to establish and maintain a comprehensive quality assurance program, for the purpose of evaluating its program strengths and needs. Program strengths and needs will be identified through the ongoing collection and analysis of data, and remediation activities.

- The SMA will conduct site visits, review documents, interview staff and individuals, in an effort to verify the effectiveness of systems the provider has in place. The SMA will notify providers of any actual or potential individual or systems problems. The provider will analyze the SMA's findings to develop and take correction actions. The SMA then examines the outcomes of corrective action to measure the effectiveness of the providers' corrective action and the need to prioritize areas in need of improvement.

2. Roles and Responsibilities

SMA/Provider

3. Frequency

Ongoing/ Continuously

4. Method for Evaluating Effectiveness of System Changes

- As part of its Quality Improvement Strategy, the State Medicaid Agency proposes to work collaboratively with providers and contracted health plans to examine systems, identify issues, evaluate factors impacting the delivery of services, design corrective actions and measure the success of system improvement. The SMA has primary responsibility for assuring that there is an effective and efficient quality management system is in place. The SMA will work with internal and external stakeholders and make recommendations regarding enhancements to the quality management system on an ongoing basis.

- The focus of system improvement will be on the discovery of issues, remediation, monitoring action taken, and making system improvement when necessary. Information gathered at the individual, provider, and contracted health plan level will be used to remedy situations on those levels and to inform overall system performance and improvements.

- On an annual basis, the provider will submit a program evaluation report which summarizes program and operational performance throughout the year. Based on the data contained in the report, input from stakeholders and the outcome of monitoring activities conducted by the SMA, the SMA will evaluate key performance measures indicators and the provider's quality management system. Results of this evaluation may demonstrate a need to change performance indicators, including changing priorities; using different approaches to ensure progress; modifying roles and responsibilities, and data sources in order to obtain the information needed for system changes.

- Upon identification of deficiencies the provider will be required to implement satisfactory improvements within timeframe identified by SMA. Each deficiency may require different timelines based on the impact the deficiency has on the delivery of services. Providers will be notified of deficiencies during face: face meetings, by email or through the SMA documentation, and submission of a discovery/remediation tool.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☑	HCBS Adult Day Health
	For ADHP users enrolled in a contracted health plan, the health plan will reimburse covered services consistent with their contracts with DHCF and with the providers. DHCF's reimbursement of services through the health plan is actuarially sound and based on historic utilization of ADHP services. Reimbursement for fee-for-service adult day health services associated with the 1915(i) HCBS State Plan Option shall be paid based upon uniform per-diem rates at two acuity levels. Acuity level 1 and Acuity level 2 services shall be reimbursed in accordance with the District of Columbia Medicaid Fee Schedule. The agency's fee schedule rate will be set as of 4/1/2020 and will be effective for services provided on or after that date. All rates are published on the agency's website at https://www.dc-medicaid.com/dcwebportal/nonsecure/feeScheduleDownload. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the DHCF Provider Web Portal available at www.dc-medicaid.com/dcwebportal/home. ADHPs will be reimbursed at two different acuity levels. To be eligible for reimbursement at acuity level 1 ADHP services, an individual shall obtain a total score of four (4) or five (5). To be eligible for reimbursement at acuity level 2 ADHP services, an individual shall obtain a total score of six (6) or higher. The specific acuity level does not affect the benefit package received by an individual. ADHP consists of one set of services that are available to all participants, regardless of acuity level. Each participant will receive services based upon their strength, preferences and health care needs as reflected by their level of need and person-centered service plan. Recognizing that some participants may have more complex needs (such as a greater need for supervision or support), DHCF has developed two reimbursement rates – one for those who meet the threshold eligibility criteria based upon their assessed needs and the other, for those whose assessed needs are higher. The enhanced rates recognize that staffing levels must increase when participants have higher acuity levels.

Adult Day Health providers are defined in this Attachment. Reimbursement for adult day health services is paid using two bundled per-diem rates that are reasonable and adequate to meet the costs incurred by an efficient and economically prudent provider. The bundled per-diem rate consists of staffing costs in addition to program materials, indirect costs, and administrative costs. Room and board are excluded in the per-diem rates.

The per diem rates are binding rates; the District will pay each provider a fixed per-diem rate. The District will pay the lesser of the per-diem rate or the amount billed by a provider in accordance with standard Medicaid payment methodology. The staffing structure used to develop the rates were tied to the program requirements and is sufficient to allow providers to meet all program requirements, but they are not bound to adhere to the wages or benefit rates included in the rate model beyond compliance with existing federal and District laws (such as our living wage laws) and the program requirements outlined in the SPA. The agency's per diem rates will be effective on the date of approval, for any services provided on or after that date. Except as otherwise noted in the Plan, State developed per-diem rates are the same for both governmental and private individual practitioners and will be published via transmittal available at https://www.dc- medicaid.com.

Staffing, wages, and benefits

The model incorporates five principle types of employees to ensure adequate staffing to meet beneficiary needs and program requirements. These include direct support personnel (DSP) providing hands-on support and care; social services professionals delivering services and programming; a program director; a registered nurse (RN); and a medical director. The cost of each of these staff types was estimated as a function of five data points: (1) the base wage or salary required to recruit and retain qualified staff and to meet District living wage law; (2) the hour paid staff would be on-duty at the program, as well as hours for paid leave; (3) the ratio of each staff member to beneficiaries attending the program; (4) the number of days in a fiscal year a program would reasonably be operating; and (5) the additional cost of providing employee benefits such as health insurance or other fringe benefits as appropriate.

Information about these five data points and how they were determined for each of the five staffing types are shown in the table below.

	Base wage or salary	Hours on duty per fiscal year	Ratio of staff member to beneficiaries	Number of operating days	Marginal addition for fringe benefits

Direct support personnel	Based on DC Living Wage	2080 (FTE) plus 80 hours paid leave	1:10 in Acuity 1; 1:4 in Acuity 2	260 (fiscal year, excluding weekends)	20%
Social services personne 1	Based on competitive wages in DC	2080 (FTE) plus 80 hours paid leave	1:20	260 (fiscal year, excluding weekends)	20%
Program director	Based on competitive wages in DC	2080 (FTE) plus 80 hours paid leave	1:40	260 (fiscal year, excluding weekends)	20%
Registered nurse	Based on competitive wages in DC	2080 (FTE) plus 80 hours paid leave	1:40	260 (fiscal year, excluding weekends)	20%
Medical director	Based on competitive wages in DC	520 (0.25 FTE)	1:40	260 (fiscal year, excluding weekends)	No benefits

These data were used to calculate annual total and per-beneficiary costs for each staffing type, which was further refined into a per-diem, per-beneficiary staffing cost.

These costs are used to develop a fee for service rate and are not a part of a CMS approved methodology to identify costs eligible for certification.

Program materials, indirect costs, and administrative costs

In addition to the staffing component, the rate includes additional funding for program materials, supplies, and indirect costs, including: (1) programming supplies; (2) food and snack costs; (3) indirect costs such as rental and building maintenance costs, utilities, telecommunications, and transportation; and (4) staff training and quality management. The estimate of these costs were based in part on qualitative data collection conducted in meetings, site visits, and phone calls with existing District health care providers, and in part on similar cost categories as reported by existing District provides via cost reporting. Annualized costs were translated into per-diem, per-

beneficiary rates using an expected operating year of 260 days and expected program size of 40 beneficiaries.

After summing the staffing component and the program and indirect costs, an additional 13% was added to the rate to reflect administrative costs. The District uses this rate for other provider types and it was used here for consistency.

Lastly, the rate was adjusted to reflect attendance rates; effectively, the rate was increased slightly to accommodate continued operating costs each day a provider is open for business, despite its complete census not attending every day.

Service Limitations

ADHP services shall not be provided to persons who reside in institutions. Providers cannot bill for services that are provided for more than five (5) days per week and for more than eight (8) hours per day. Additionally, providers will not be reimbursed for ADHP services if the participant is receiving the following services concurrently (i.e., during the same hours on the date of service):

(a) Day Habilitation and 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);
(c) Personal Care Aide services; (State Plan and 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.

A provider will also not be reimbursed for ADHP services if the participant is receiving intensive day treatment mental health rehabilitation services during a twenty-four (24) period that immediately precedes or follows the receipt of ADHP services, to ensure that the participant is receiving services in the setting most appropriate to his/her clinical needs.

☐ HCBS Habilitation

☐ HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:

☐ HCBS Day Treatment or Other Partial Hospitalization Services

☐ HCBS Psychosocial Rehabilitation

	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☐	Other Services (specify below)	