

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

A. The State of Dist. of Columbia requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:

Elderly & Persons With Physical Disabilities Waiver Amendment - November 2023

C. Waiver Number:DC.0334

Original Base Waiver Number: DC.0334.

D. Amendment Number:

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

01/01/24

Approved Effective Date of Waiver being Amended: 02/07/22

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

This amendment makes the following changes to the rates and reimbursement methodologies for Assisted Living Services and Case Management Services:

- Allows for continuation of the temporary fifteen percent (15%) increase to the daily reimbursement rate for Assisted Living Services that was approved under Section §1915(c) Waiver Appendix K authority in response to the COVID-19 public health emergency. The continuation of this increased rate is necessary to account for higher costs associated with utilization of skilled care by beneficiaries residing in assisted living facilities than had been assumed when determining the existing base rate. DHCF intends for the fifteen percent (15%) rate increase to remain in place until such future date that a more comprehensive update to the Assisted Living Services reimbursement methodology is finalized.

- Increases the Case Management Services reimbursement rate and updates the reimbursement methodology to:

(a) Include consideration of administrative cost allowances and sufficiency of funding for case manager wages in determining the monthly capitation rate; and (b) Allow for annual inflation-based adjustments to the monthly capitation rate.

DHCF intends for these changes to Case Management Services to remain in place until a comprehensive rate study has been completed and corresponding updates to the reimbursement methodology implemented.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	<input type="text"/>
Appendix A Waiver Administration and Operation	<input type="text"/>
Appendix B Participant Access and Eligibility	<input type="text"/>
Appendix C Participant Services	<input type="text"/>
Appendix D Participant Centered Service Planning and Delivery	<input type="text"/>
Appendix E Participant Direction of Services	<input type="text"/>
Appendix F Participant Rights	<input type="text"/>
Appendix G Participant Safeguards	<input type="text"/>
Appendix H	<input type="text"/>
Appendix I Financial Accountability	I-2; I-5
Appendix J Cost-Neutrality Demonstration	J-2

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- Modify target group(s)
- Modify Medicaid eligibility
- Add/delete services
- Revise service specifications
- Revise provider qualifications
- Increase/decrease number of participants
- Revise cost neutrality demonstration
- Add participant-direction of services
- Other

Specify:

Update reimbursement methodology and increase reimbursement rates for assisted living services and case management services.

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

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Elderly & Persons With Physical Disabilities Waiver Amendment - November 2023

C. Type of Request: amendment

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

3 years 5 years

Original Base Waiver Number: DC.0334

Draft ID: DC.003.05.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 02/01/22

Approved Effective Date of Waiver being Amended: 02/07/22

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155

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

N/A

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

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

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

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

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

§1915(b)(2) (central broker)

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

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

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

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

PURPOSE:

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

GOAL:

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

OBJECTIVES:

- (1) Ensure the target populations remain in home and community-based settings that meet all of the requirements of the HCBS regulation under 42 CFR 441.301.
- (2) Ensure the target populations have access to supports that are participant-directed.
- (3) Enhance the quality of life for the target populations by preserving their independence and relationships with family and friends.
- (4) Expand the range of long-term services and supports available for the target populations. Implement a conflict-free case management and person-centered planning delivery process in accordance with the requirements of 42 CFR 441.301.

ORGANIZATIONAL STRUCTURE:

DHCF administers the waiver, oversees contracted entities and providers, and develops and oversees its processes.

SERVICE DELIVERY METHODS:

EPD waiver services have defined target populations (elders and individuals with physical disabilities) and specific rules outlining the implementation of services. Waiver participants are served either by EPD waiver providers enrolled by DHCF on a fee-for-service basis, or by the contracted D-SNP with which the participant is concurrently enrolled. Provider agencies enrolled by DHCF who serve EPD waiver participants must complete the provider application, meet the waiver service requirements, and have a signed provider agreement with DHCF.

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

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

Yes. This waiver provides participant direction opportunities. *Appendix E is required.*

No. This waiver does not provide participant direction opportunities. *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

Not Applicable

No

Yes

C. Statewide. Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

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

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

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

5. Assurances

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

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

To solicit public input into the waiver amendment application, the Department posted a notice of its intent to amend the EPD waiver along with a copy of the proposed waiver amendment in its entirety to its website (<https://dhcf.dc.gov/epd-waiver-amendment>) on August 11, 2023 and published this notice in the August 11, 2023 issue of the DC Register (<https://www.dcregs.dc.gov/Common/DCR/Issues/IssueDetailPage.aspx?issueID=1046>).

DESCRIPTION OF ANY COMMENTS RECEIVED AND DHCF'S RESPONSES

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

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

7. Contact Person(s)

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

Last Name:

Katherine

First Name:

Rogers

Title:

Director, Long Term Care Administration

Agency:

Department of Health Care Finance

Address:

441 4th Street NW

Address 2:

Suite 900S

City:

Washington

State:

Dist. of Columbia

Zip:

20001

Phone:

(202) 442-5818 Ext: TTY

Fax:

(202) 442-8114

E-mail:

katherine.rogers@dc.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Dist. of Columbia

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Senior Deputy Director / Medicaid Director

Agency:

Department of Health Care Finance

Address:

441 4th Street NW

Address 2:

Suite 900

City:

Washington

State:

Dist. of Columbia

Zip:

20001

Phone:

(202) 442-5988

Ext:

TTY

Fax:

(202) 442-4790

E-mail:

Attachments

melisa.byrd@dc.gov

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver

complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required. Note that Appendix C-5 HCBS Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here. Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The District assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the District's most recent 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.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

Department of Health Care Finance, Long Term Care Administration (LTCA)

(Do not complete item A-2)

Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

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

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

DHCF’s LTCSS contractor determines each applicant/beneficiary's required level of care by conducting a face-to-face assessment of the individual’s functional, cognitive/behavioral, and skilled care needs using a standardized needs-based assessment tool for LTCSS. The standardized assessment tool also evaluates an individual’s strengths and preferences, available service, housing options, and availability of unpaid caregiver support in determining the assistance required to meet the applicant/beneficiary's needs.

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

DHCF utilizes a Quality Improvement Organization (QIO) for some waiver operational and administrative functions. The QIO functions for the EPD Waiver are to prior authorize EPD Waiver services, and perform person-centered individualized service plan reviews to determine if the service plan and the services required are appropriate to meet the needs of the participant and if the services are correctly identified.

DHCF uses contracted dual eligible special needs plans (D-SNPs) to coordinate, authorize, finance, and monitor covered Medicaid services, including EPD Waiver services, for Medicaid beneficiaries who select D-SNP coverage. The contracted D-SNP offers both utilization management and comprehensive, integrated care management activities through key elements of its model of care, including health risk assessments, individualized care plans reflecting the full scope of all services required by an enrollee, care management by an interdisciplinary care team, and provider oversight.

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

Appendix A: Waiver Administration and Operation

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

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

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

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

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

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

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

In its oversight role for the care delivered by contract D-SNP health plans, the DHCF Contract Administrator reviews monthly, quarterly and annual reports submitted by the D-SNPs in a format determined or approved by DHCF. The Contract Administrator reviews the reports and assesses whether there are gaps or trends with services, contractor performance, and completion and quality of D-SNP requirements identified in the contract. DHCF also conducts reviews of care team activities and other documentation at the individual enrollee level. On an ongoing basis, DHCF hosts regular face-to-face and virtual meetings with contractor staff to monitor performance. There are daily, ad hoc discussions on issues that may arise outside of routine meetings.

Appendix A: Waiver Administration and Operation

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

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

(3) A.a.3 Percent and type (by assurance) of performance measure indicators in compliance. N = Number of performance measures performing above 86%. D = Total number of performance measures reviewed.

Data Source (Select one):

Trends, remediation actions proposed / taken

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

(2) A.a.2 Percent of providers with an accepted Opportunity for Improvement Plan (OFIP).
Numerator = Number of providers with an accepted OFIP. Denominator = Number of provider records reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>

Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

(1) A.a.1 Percentage of waiver participants who meet financial eligibility. Numerator = Total number of waiver participants who meet financial eligibility. Denominator = Total number of waiver participants.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

FMS reports

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="FMS"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Continuously and Ongoing
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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

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

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

Performance measures are derived from the actual EPD waiver measures approved by CMS or other measures that the program feels are important to monitor. A report card of measures is shared between the LTCA Oversight and Monitoring Division and DQHO on a regular basis for tracking and trending waiver performance. Once performance measure rates are submitted to the DQHO, an analysis is completed on individual performance measures and overall program performance.

The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF.

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

DQHO partners with LTCA to conduct comprehensive review for assessing the overall performance of the EPD Waiver. It includes an iterative process for assessing performance, identifies opportunities for improvement, and outlines recommendations for targeted quality improvement processes and measuring and monitoring the program's overall effectiveness. Additionally, all applicable providers shall be subject to quality standards, including but not limited to, guidance issued by the CMS, and rules issued by DHCF's quality improvement activities.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Remediation and fixing individual problems are the responsibility of the Long Term Care Administration (LTCA) at DHCF. DHCF has two approaches for remediation and problem solving.

The first functions as a grievance resolution process and aims to resolve beneficiaries’ problems within 24 hours of presentation. This approach is not a systematic quality improvement intervention, but an intervention to ensure foremost that a beneficiary is not harmed by the failure of the EPD waiver program to operate in the way in which it is intended. Such grievances are handled by LTCA staff supporting waiver operations. These staff have access to the District’s eligibility and enrollment files, prior authorization records, and clinical case management system. These staff document beneficiary complaints and requests for assistance in a secure, browser-based online system.

When an issue is determined to represent a systemic problem (e.g., from data from contractual oversight, complaints tracking, provider monitoring activities, findings of DHCF’s Surveillance/Utilization Review (SURS)/Utilization Management unit), a systemic approach is applied. Systemic remediation activity occurs primarily through formal written communications to providers that identify the systemic problem and the actions that are required to remedy it. DHCF holds weekly, monthly, and ad hoc meetings with waiver providers to review performance-related issues in the aggregate, and provide education, training, and guidance on needed improvements.

Finally DHCF’s Surveillance/Utilization Review (SURS)/Utilization Management unit monitors providers compliance with rules governing the EPD waiver program; and recoups payments when there is evidence of noncompliance.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

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

No

Yes

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

As mentioned in question a.ii. (Methods for Discovery), DHCF has in place several mechanisms to monitor and analyze EPD waiver performance. The LTCA Oversight and Monitoring Division conducts compliance reviews on performance measures of all waiver assurances. The LTCA Oversight and Monitoring Division is responsible for the discovery and remediation process of individual and systemic issues. The findings are shared with the providers for submitting acceptable opportunity for improvement action (OFIP) and continuous quality improvement initiatives for systemic improvement. The LTCA Division is also responsible for alerting providers of immediate health and safety (individual/systemic) concerns through its electronic discovery remediation process.

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

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

The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF.

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

DQHO partners with LTCA to conduct comprehensive review for assessing the overall performance of the EPD Waiver. It includes an iterative process for assessing performance, identifies opportunities for improvement, and outlines recommendations for targeted quality improvement processes and measuring and monitoring the program’s overall effectiveness. Additionally, all applicable providers shall be subject to quality standards, including but not limited to, guidance issued by the CMS, and rules issued by DHCF’s quality improvement activities.

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged	65		
		Disabled (Physical)	18	64	
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

The group is inclusive of individuals aged 65 and older and individuals aged 18-64 with one or more physical disabilities, who meet at least the functional criteria for admission to a nursing facility ("nursing facility level of care"). Individuals that participate in the EPD waiver must live in a private residence, apartment, or an assisted living facility approved as an EPD waiver provider.

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

Not applicable. There is no maximum age limit

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

Specify:

The maximum age limit for individuals in the waiver's physically disabled target subgroup is 64 years. The minimum age for individuals in the waiver's elderly target subgroup is 65 years, but there is no maximum age limit. Therefore, when an physically disabled waiver beneficiary turns 65, he/she transitions into the waiver's elderly subgroup, which facilitates a continuity of care for the individual.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

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

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

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

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	6060
Year 2	6160
Year 3	6260
Year 4	6360
Year 5	6460

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

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes	
Community Transitions of institutionalized persons	<input type="checkbox"/>
Enrollees aging out of HSCSN enrollment	<input type="checkbox"/>

Appendix B: Participant Access and Eligibility

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

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

Community Transitions of institutionalized persons

Purpose (*describe*):

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

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

Describe how the amount of reserved capacity was determined:

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

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

Waiver Year	Capacity Reserved
Year 1	60
Year 2	60
Year 3	60
Year 4	60
Year 5	60

Appendix B: Participant Access and Eligibility

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

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

Enrollees aging out of HSCSN enrollment

Purpose (describe):

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

Describe how the amount of reserved capacity was determined:

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

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

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

Eligibility criteria consist of the following: 1) Medicaid eligibility with a maximum monthly income of three hundred percent (300%) of Supplemental Security Income (SSI); 2) The individual requires the level of care furnished in a nursing facility under Medicaid; 3) The individual is either age 65 or older, or age 18-64 with one or more physical disabilities; and 4) The individual is not an inpatient of a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities.

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a (*select one*):

§1634 State

SSI Criteria State

209(b) State

2. Miller Trust State.

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

No

Yes

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

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

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

SSI recipients

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

Optional state supplement recipients

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

Select one:

100% of the Federal poverty level (FPL)

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

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)

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

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

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

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

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

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

Specify:

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

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

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

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

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable (see instructions)

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

--

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The state uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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

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

Select one:

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

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

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

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Other*Specify:*

Performance of initial level of care evaluations and annual level of care reevaluations are conducted by the District's Long Term Care Services and Supports (LTCSS) contractor.

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

The initial level of care evaluations are performed by a Registered Nurse (RN) or Licensed Independent Clinical Social Worker (LICSW), licensed in the District and hired by/under contract with DHCF or its LTCSS contractor.

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

A Registered Nurse (RN) or Licensed Independent Clinical Social Worker (LICSW) hired by/under contract with DHCF or its LTCSS contractor conduct face-to-face assessments of each applicant/beneficiary to determine if he/she requires a nursing facility level of care. The face-to-face assessment utilizes a standardized assessment tool (interRAI Home Care Assessment System) to evaluate 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, 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., communication impairments, hallucinations or delusions, physical/verbal behavioral symptoms, eloping or wandering).

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

Completion of the assessment will yield a final total score determined by adding up the individual scores from the three domains. To be eligible for participation in the EPD waiver, an individual must obtain a score of nine (9) or higher to indicate the need for a nursing facility level of care.

Each applicant/beneficiary shall initially be determined eligible for the waiver based upon the results of a standardized face-to-face, conflict free assessment of functional, behavioral/cognitive, and skilled care needs, conducted by a registered nurse (RN) or licensed independent clinical social worker (LICSW) employed by DHCF or its LTCSS contractor. A face-to-face reassessment shall be conducted for each beneficiary at least once every twelve (12) months or upon a significant change in the beneficiary's health status. Requests for reassessments shall be made by the beneficiary's case manager.

Case managers or D-SNP ICTs complete an initial evaluation of the beneficiary's current and historical medical, social, and functional status to determine level of need; conduct monthly, face-to-face home visits to monitor ongoing conditions and provide coordination of care; and submit requests for annual face-to-face reassessments of the beneficiary's continued need for EPD waiver services. Case managers and D-SNP ICTs also are responsible for reviewing the results of the beneficiary's face-to-face assessment/reassessments, for completing the beneficiary's comprehensive PCSP, and also reviewing the comprehensive PCSPs on a quarterly and annual basis.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of

care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

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

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

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

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

INITIAL ASSESSMENT PROCESS

For all individuals not yet enrolled in Medicaid, or individuals currently enrolled in fee-for-service District Medicaid, seeking to enroll in the EPD waiver program, the ADRC or its designee will be assigned to assist with the application process. Once physician certification is received, the ADRC or its designee is responsible for assisting the applicant with requesting a face-to-face assessment of his/her level of care needs. The face-to-face assessment is conducted by an RN or LICSW employed by DHCF or its LTCSS contractor, using the standardized assessment tool (interRAI Home Care Assessment System). If the assessment determines that an applicant/beneficiary requires a nursing facility level of care, and is therefore meets the functional eligibility criteria for enrollment in the EPD waiver, the ADRC or its designee is responsible for ensuring that the information is transmitted to ESA.

Once determined that the beneficiary meets or continues to meet nursing facility level of care, ESA is responsible for determining whether the applicant is financially eligible. The disposition of ESA's financial eligibility assessment is sent to DHCF and ADRC, at which point eligibility notices are sent to the applicant and/or authorized representative.

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

For individuals enrolled in a contracted D-SNP, the D-SNP will assist with the initial assessment process. For the initial assessment process, the D-SNP will be responsible for submitting a request, on the waiver applicant's/participant's behalf, to DHCF's LTCSS contractor for the face-to-face level of care assessment. Following completion of an assessment determining the applicant/participant meets the functional eligibility criteria for waiver enrollment, the D-SNP is then responsible for transmitting the information to DHCF and ESA.

REASSESSMENT PROCESS

The reassessment process is the same as the initial assessment process, except that ADRC does not play a role during the reassessment period. At least one hundred and twenty (120) days in advance of the recertification deadline, DHCF's Long Term Care Administration sends a notice to the CMAs to alert them of the recertification due dates.

Case managers complete an initial evaluation of the beneficiary's current and historical medical, social, and functional status to determine level of need; conduct monthly, face-to-face home visits to monitor ongoing conditions and provide coordination of care; and submit requests for annual face-to-face reassessments of the beneficiary's continued need for EPD waiver services. Case managers also are responsible for reviewing the results of the beneficiary's face-to-face assessment/reassessments, for completing the beneficiary's comprehensive PCSP, and also reviewing the PCSP on a quarterly and annual basis.

Similar to the initial assessment process, ESA sends the disposition of its financial eligibility reassessment to DHCF and ADRC, mails the eligibility notice to the EPD waiver beneficiary and/or authorized representative, and notifies the CMA and service provider(s) via the electronic case management system. The CMA's case manager contacts the beneficiary enrolled in the waiver and ensures that any necessary modifications to his/her person-centered service plan are made during the beneficiary's annual PCSP meeting.

For individuals enrolled in a contracted D-SNP, the D-SNP will assist with the reassessment process. For the reassessment process, the D-SNP's ICT is responsible for submitting a request, on the waiver participant's behalf, to DHCF's LTCSS contractor for annual face-to-face level of care reassessments. Following completion of a reassessment, the D-SNP ICT is responsible for reviewing the results, transmitting the information to DHCF, and updating the participant's PCSP accordingly.

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

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

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

The qualifications are different.

Specify the qualifications:

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

ESA is responsible for determining the financial eligibility of those beneficiaries determined to require a nursing facility level of care based on their annual reassessment, conducted by an RN or LICSW employed by DHCF or its LTCSS contractor, using the standardized face-to-face assessment tool.

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

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

The records of evaluations and re-evaluations of level of care are stored in the Medicaid electronic case management system, which is maintained by the Medicaid agency (DHCF) at its central office.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

a. Sub-assurance: *An evaluation for LOC is provided to all applicants for whom there is reasonable*

indication that services may be needed in the future.

Performance Measures

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

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

Performance Measure:

(4) B.a.1 Percentage of new waiver enrollees who have a level of care determination indicating need of nursing home facility care before receiving waiver services. Numerator = Number of new enrollees who have a level of care determination indicating need of nursing facility care before receiving waiver services. Denominator = Total number of new waiver enrollees.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports generated by QIO

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>

	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

(5) B.c.1 Percent of new waiver enrollees' initial LOC determinations made in accordance with written policies and procedures established for the contractor by the state agency. Numerator=Number of initial LOC determinations made in accordance with written policies and procedures established for the contractor by the state agency. Denominator= Number of initial LOC determinations completed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DC Care Connect

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Contracted D-SNP"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

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

DHCF has in place several mechanisms to monitor and analyze EPD waiver performance. The Long Term Care Administration (LTCA) Oversight and Monitoring Division conducts compliance reviews on performance measures of all waiver assurances. The LTCA Oversight and Monitoring Division is responsible for the discovery and remediation process of individual and systemic issues. The findings are shared with the providers for submitting acceptable opportunity for improvement action (OFIP) and continuous quality improvement initiatives for systemic improvement. LTCA is also responsible for alerting providers of immediate health and safety (individual/systemic) concerns through its electronic discovery remediation process.

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

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

The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF.

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

The findings are shared with the providers for submitting acceptable opportunity for improvement action (OFIP) and continuous quality improvement initiatives for systemic improvement. The LTCA Division is also responsible for alerting providers of immediate health and safety (individual/systemic) concerns through its electronic discovery remediation process.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Remediation and fixing individual problems are the responsibility of the State Agency's Long Term Care Administration (LTCA), Elders and Persons with Physical Disabilities Branch (EPPD) and its Manager. EPPD has two approaches for remediation and problem solving. The first of the two approaches focuses on individual beneficiaries and aims to resolve each beneficiary's problems within 24 hours of its presentation. It is not a systematic quality improvement intervention, but an intervention to ensure that foremost a beneficiary is not harmed by the failure of the EPD program to operate in the way in which it is intended.

DHCF staff have access to the Districts eligibility and enrollment files, and MMISadjunct database on EPD Waiver enrollment and case management. They can identify the status of an application, whether or not a LOC determination has been made, the result of the LOC evaluation, and these staff intervene quickly to respond to issues related to LOC determinations. These staff document beneficiary complaints and requests for assistance in a tracking log book maintained by EPPD.

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

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="319 521 794 604" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="865 808 1339 891" type="text"/>

c. Timelines

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

No

Yes

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

The District’s DQHO has a Program Analyst dedicated to the LTCA and the EPD waiver. This Program Analyst has assisted in development and implementation of an EPD work plan to ensure that all elements of the waiver are in compliance. The Analyst also chairs a Quality Management Committee meeting on a monthly basis that implements the Quality Strategy outline in Appendix H including a Continuous Quality Improvement plan. This process includes the development of Quality Improvement Projects for any assurance that is performing below 86%. All performance measure indicators are in compliance and performing above 95% compliance. The District feels this demonstrates interventions that changed the enrollment process has improved the compliance with its policies and procedures for LOC determinations.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The contractual agencies are responsible for obtaining interpretation services.

In accordance with District rulemaking, each provider of Waiver services shall establish a plan to adequately provide services to non English speaking participants. The provider shall identify the necessary resources and individuals in order to implement the plan. Identification of necessary resources may include referring the recipient to another services provider agency or businesses with staff that is able to meet the particular language needs of the recipient.

DHCF also has an established language interpreter service.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Day Health		
Statutory Service	Case Management		
Statutory Service	Homemaker		
Statutory Service	Personal Care Aide		
Statutory Service	Respite		
Other Service	Assisted Living		
Other Service	Chore Aide		
Other Service	Community Transition Services		
Other Service	DSNP/Managed Care Capitated Waiver Services		
Other Service	Environment Accessibility and Adaptation Services		
Other Service	Individual Directed Goods and Services		
Other Service	Participant-Directed Community Support Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Adult day health services are designed to encourage 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/maintain 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, including administration of medication and/or assistance in self-administration of medication provided by a Registered Nurse (RN) or Certified Medication Aide (MA-C) in accordance with District regulations. Persons enrolled in the waiver will also have the option of receiving 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. Meals provided as part of these services shall not constitute a full nutritional regimen (3 meals per day). All services will be offered under the person's person-centered service plan and be tailored in accordance with their unique needs and choices.

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, and specified in Attachment #2 in the Main Section of the Application.

The adult day health service reimbursement does not include transportation costs. Adult day health providers are responsible for coordinating transportation to any off-site visits by using Non-Emergency Medical Transportation (NEMT) benefits available through the individual's Medicaid coverage, whether through the fee-for-service Broker, Medical Transportation Management, Inc. (MTM) or the D-SNP's transportation services.

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

- (1) A provider shall not be reimbursed for adult day health services if they do not meet the settings 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 health services if the waiver participant is concurrently receiving any of the following services:
 - (a) Day Habilitation or Individualized Day Supports under another 1915(c) waiver, including the District's Waiver for Individuals with Intellectual and Developmental Disabilities (IDD Waiver);
 - (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) waiver);
 - (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; or
 - (e) 1915(i) State Plan HCBS services.
- (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 at the same time, or 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.
- (4) 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.
- (5) Adult day health services may be used in combination or on the same day as PCA services, as long as these services are not billed concurrently or during the same time.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Health Provider

Provider Qualifications

License (*specify*):

All professionals providing services within the ADHP 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 (*specify*):

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

Other Standard (*specify*):

- (1) Have a Medicaid Provider Agreement with DHCF to be enrolled as an adult day health provider under the EPD Waiver ;
- (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; and
- (3) Providers of adult day health services under the EPD Waiver shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics determined by DHCF.

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 compliance with EPD Waiver programmatic requirements.

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 by DHCF Division of Public and Private Provider Services.

Contracted D-SNPs must enroll and credential qualified EPD waiver providers, and must ensure that all qualified waiver providers are known to DHCF.

Frequency of Verification:

DHCF's Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process and during the revalidation process every five (5) years for EPD waiver providers.

DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Contracted D-SNPs shall verify adult day health provider qualifications no less frequently than once every five (5) years, and in accordance with requirements of plan accreditation and DHCF oversight.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

The conflict-free case management (CM) service is designed to ensure that the 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 integrated settings while receiving services in the community to the same degree as people who do not receive Medicaid funded services. CM services are provided to individuals who are residing in a community setting or transitioning to a community setting following an institutional stay. Transitional CM services are temporary and are only provided to facilitate a person's transition back to the community if the person is institutionalized; regular CM services are continuously provided during the person's enrollment in the waiver when they are residing in the community. Transitional CM services may be provided for a period not to exceed 120 days and include assistance connecting or re-connecting to community resources/services and discharge planning.

The CM 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 he/she may be entitled. The CM's role is to support the person in developing a written comprehensive person-centered plan (PCSP) for Medicaid and non-Medicaid services (including community resources) that reflects the person's strengths, preferences, community and family supports, personal goals, financial resources, and assessed needs. Based on this plan, the CM assists the person in accessing a mix of services detailed in the PCSP in the most integrated community setting appropriate to his/her needs, and provides ongoing monitoring of the person's use of the LTCSS detailed in the PCSP. Additionally, the CM advocates on the person's behalf within service networks while ensuring the person stays connected to all public benefits for which he/she is eligible.

I. Requirements for Person Centered Service Planning

The case manager shall commit to making services fit persons, rather than making persons fit services, and enable a person-centered process, directed by the person with LTCSS needs, 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 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;
- (4) Ensures that information shared with the person is aligned to his or her 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 of the HHS Office on Minority Health Standards National Standards on Culturally and Linguistically Appropriate Services (CLAS) <https://www.thinkculturalhealth.hhs.gov/content/clas.asp>. If needed, auxiliary aids and services shall be provided;
- (5) Provides meaningful access to persons and/or their representatives with limited English proficiency, 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 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 service planning process.

II. Development of the PCSP

The case manager shall ensure that the PCSP highlights the waiver participant's strengths and that it aligns with the waiver participant's quality of life goals, service and support needs, and preferences. Specifically, the PCSP must:

- (1) Document the person's strengths and positive attributes at the beginning of the plan;
- (2) Document the goals and risks of the person and/or representative, 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, as appropriate;
- (4) Be in a language, dialect, and at the literacy level needed to be understandable by the person and/or his/her representative;
- (5) Specify the other contributors chosen by the person to engage in the development and monitoring the implementation of the PCSP;
- (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 community resources;

- (8) Prevent duplicative, unnecessary or inappropriate services by identifying only the necessary services chosen by the person;
- (9) Identify the specific persons, health care providers, and/or other entities providing services and supports;
- (10) Develop, in partnership with the person, a risk mitigation plan and a back-up emergency plan; which 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 health and safety needs warrant 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 the Services My Way Program;
- (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 PCSP from those who participated in its planning and development, with mandatory signatures of the person and the case manager.
- (16) All contributors chosen and invited by the person to participate in the PCSP process must receive a copy of the completed PCSP, or a component of the plan, as determined by the person.

III. Implementing and Monitoring the PCSP

The case manager shall work with the waiver participant to implement the PCSP. 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 PCSP, 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 PCSP in type, scope, duration, and frequency.
- (4) Review and update the PCSP at least every 12 months or when the person's functional needs change, circumstances change, quality of life goals change, or at the person's request.
 - (a) The CM must respond to personal requests for updates within 48 hours, with completion of the update within 7 days.
 - (b) The updated PCSP must be done via face-to-face discussions with the participant, other contributors chosen and invited by the participant, and representatives of the participant's interdisciplinary team.
 - (c) The updated PCSP 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 person.
 - (d) The updated PCSP must include approval signatures from those who participated in PCSP planning and development, with mandatory signatures of the person and the CM, and be shared with other EPD Waiver providers, with the permission of the person, to facilitate a person's care coordination.
- (5) Ensure the person continues to meet the EPD-required Level of Care (LOC)
 - (a) Review the initial assessment at least every 12 months to determine if a person has had a significant change in health status.
 - (b) If the CM's review reflects a change (i.e., improvement or worsened) in health status, the CM shall note changes, and shall request a LTCSS assessment by DHCF or its designee (via submission of a signed POF from the person's physician or APRN).
 - (c) If there is no change in health status, the CM will submit request for the participant to have a face-to-face reassessment at least once every 12 months.
- (6) Assist in obtaining required documents for the initiation of and on-going maintenance of services (e.g., securing physician orders, financial documents, etc.), particularly at the time of required renewals and recertification.
 - (a) The application for recertification should be submitted 60 days prior to the Medicaid expiration date.
 - (b) CMs should begin working on the recertification package upon receipt of the required documents from DHCF or its agent, or no later than 90 days prior to the Medicaid expiration date, whichever is earlier.
- (7) Ensure quality of care and service provision, including identification and resolution of problems with providers

and services identified in the PCSP.

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

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

(10) Ensure that Medicaid renewals and any required re-certifications are complete before the end of a person's renewal or certification period, including ensuring the person obtains annual LOC redetermination, if appropriate.

(11) Monitor implementation of PCSP via monthly check-ins that are documented in DC's electronic CM system to ensure that persons are receiving services per the plan.

IV. Conflict Free Requirements

Case Managers shall not:

(1) Be related by blood or marriage to the waiver participant, or to any paid caregiver of the participant;

(2) Be financially responsible for the waiver participant, or be empowered to make financial or health decisions on the participant's behalf;

(3) Hold financial interest or have a financial relationship, defined under 42 CFR 411.354, in any entity that is paid to provide care for the waiver participant; and

(4) Be employed by or under contract to other direct program service providers 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 waiver participant relative to his/her PCSP:

(1) Conducting monthly home visits, at minimum, to check on the waiver participant and to ensure services are provided in accordance with the PCSP;

(2) Communicating and coordinating with the waiver participant whose plan is being developed, other contributors chosen and invited by the participant, and representatives of the participant's interdisciplinary team, as needed and possible;

(3) Monitoring the implementation of the PCSP;

(4) Communicating, coordinating care and follow-up on service delivery issues until they are resolved;

(5) Documenting all case management activities;

(6) Conducting functional evaluation and assisting the waiver participant to obtain level of care redetermination 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 PCSP.

The following limits are applicable to billing:

(1) For transitional case management services provided during a person's institutional stay, billing for those services may occur only after the person returns to the community setting (not during the person's institutional stay). Billing shall be contingent upon demonstration of activities that occurred during the person's institutional stay to facilitate transition to the community such as discharge planning, and assistance in accessing community resources.

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

(3) Note that service providers:

- May not receive Medicaid reimbursement for case management services to persons who are not Medicaid beneficiaries ; and

- May not provide medical, financial, or legal services (except for referral to qualified individuals, agencies or program).

(4) EPD waiver participants cannot be simultaneously enrolled in a Health Home.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency

Provider Type:

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 (Nursing, Social Work, Psychology, Counseling or Therapies), and have a Masters and one year of experience with the population, with either a degree in Social work, Psychology, Counseling, Rehabilitation, Nursing, Gerontology, sociology, or Therapy (OT, PT, Or Speech); or a Bachelors degree and the above current licensure and 2 years of experience with the population; or a Registered Nurse [RN] can have an Associate Degree and 3 years of experience.

Certificate (specify):

N/A

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 Quality Assurance 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 45 individuals/cases total, across all case management agencies, at any given point in time. The case load for each case manager must be commensurate with his/her number of hours worked per week.
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 PCSP, 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 PCSP. Each case management service provider or its designee shall complete and submit the PCSP for review and approval within ten (10) business days of conducting the initial evaluation.
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 PCSP, as per participant request and/or as appropriate.
12. Development of the PCSP 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 PCSP is provided to the State Agency (or its designee) for approval of services recommended in the PCSP. The State Agency (or its designee) will approve or disapprove the services recommended in the PCSP 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 the choice to participate in the PDS program and/or offered the free choice of all qualified Medicaid providers of each service included in his/her written PCSP.
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 PCSP, 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 PCSP, 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; and

23. Each case manager must administer a Health Status Evaluation Attestation at least annually to determine if there was a significant change in health condition.

2) EPD Waiver Case managers shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF prior to providing case management services.

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 compliance with programmatic requirements. 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 monitor providers to ensure compliance with EPD Waiver programmatic requirements 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-validation process once every five (5) years. DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08050 homemaker

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Services consisting of general household activities (food preparation and storage, 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. These services do not need to be supervised by a RN.

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

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency
Agency	Licensed provider of housekeeping services

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Homemaker

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*):

N/A

Other Standard (*specify*):

- 1) If a home care agency enrolled to provide homemaker services, 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;
- 2) Be enrolled as an EPD Waiver Provider of Homemaker services;
- 3) Have a current Medicaid provider agreement on file with the DHCF before providing any waiver services; and
- 4) Providers must have bylaws or similar documents regulating conduct consistent with waiver and regulatory requirements; and
- 5) Home Care Agencies providing homemaker services under the EPD Waiver shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.

A person providing homemaker services shall meet the following:

- 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 be certified as a Home Health Aide in accordance with Chapter 93 of Title 17 of the District of Columbia Municipal Regulations or complete the annual training requirements for homemakers specified in this Appendix (see Other standards under Provider Qualifications); ;
- 4) Maintain an updated CPR certificate; and
- 5) Pass 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 compliance with EPD Waiver programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Contracted D-SNPs must enroll and credential qualified EPD waiver providers, and must ensure that all qualified waiver providers are known to DHCF.

Frequency of Verification:

DHCF's Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements at least annually.

DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the revalidation process once every three (3) years. DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Contracted D-SNPs shall verify provider qualifications no less frequently than once every three (3) years, and in accordance with requirements of plan accreditation and DHCF oversight.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Licensed provider of housekeeping services

Provider Qualifications

License (specify):

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):

N/A

Other Standard (specify):

Agencies/Providers must -

- 1) Be enrolled as an EPD Waiver Provider of Homemaker services;
- 2) Have a current Medicaid provider agreement on file with the DHCF before providing any waiver services; and
- 3) Providers must have bylaws or similar documents regulating conduct consistent with waiver and regulatory requirements.

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 the annual training requirements for homemakers as specified in this section;
- 4) Maintain an updated CPR certificate; and
- 5) Pass a criminal background check.

If person providing housekeeping services is employed by a business licensed to perform housekeeping services, obtain a minimum of eight (8) hours of training annually in the following areas:

- a. Residents rights;
- b. Communicating effectively with persons enrolled in the waiver;
- c. Preventing Abuse, Neglect and Exploitation;
- d. Controlling the spread of disease and infection;
- e. Changing linens and bed bug prevention;
- f. Food preparation, handling, and storage;
- g. Safe handling of cleaning chemicals (use of gloves, goggles/masks);
- h. Handling hazardous waste;
- i. Blood-borne pathogens and bodily fluids; and
- j. Instructions on the following-
 - i. Dusting
 - ii. Maintenance of floors (mopping/vacuuuming)
 - iii. Laundry and safe use of detergents
 - iv. Trash handling
 - v. Cleaning Walls and ceiling
 - vi. Kitchen/Bathroom cleaning/maintenance

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 compliance with EPD Waiver programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Contracted D-SNPs must enroll and credential qualified EPD waiver providers, and must ensure that all qualified waiver providers are known to DHCF.

Frequency of Verification:

DHCF’s Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements at least annually. Contracted D-SNPs must enroll and credential qualified EPD waiver providers, and must ensure that all qualified waiver providers are known to DHCF.

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). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Contracted D-SNPs shall verify provider qualifications no less frequently than once every five (5) years, and in accordance with requirements of plan accreditation and DHCF oversight.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Care Aide

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Tasks include cueing, safety monitoring, assistance with activities of daily living and assistance with instrumental activities of daily living. Services involve assistance with one or more activities of daily living that is rendered by a qualified personal care aide (PCA) under the supervision of a registered nurse. The scope and nature of these services do not differ from personal care services furnished under the State plan but the waiver service differs from state plan services in that it allows the option for individuals to participant-direct their PCA waiver services, which is not an option under the state plan personal care services.

For waiver participants under the age of 21, the PCA services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

For adult waiver participants 21 and older who do not choose to self-direct personal care services must first access needed personal care services via the state plan personal care service up to the state plan service limit of 8 hours per day; if these adult waiver participants demonstrate the need for more than 8 hours of this service in accordance with their person-centered service plan, they can then access this PCA waiver service for their remaining PCA service needs that are over/above the 8 hours per day.

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

(1) (a) To be eligible for waiver PCA services, they must be included in the person's PCSP, and the person must be in receipt of a service authorization for EPD waiver services as established by the receipt of a score of nine (9) or higher on the standardized LTCSS face-to-face assessment, which equates to a nursing home level of care (or higher), including the need for extensive assistance or total dependence with two or more ADLs.

(b) Reimbursement for waiver PCA services shall not exceed sixteen (16) hours per day per EPD waiver beneficiary.

(c) All waiver PCA services related to meal preparation shall be in accordance with the person's dietary guidelines, including low sodium intake guidelines, or other restrictions, and also take into account any cultural/religious dietary preferences in accordance with the PCSP.

(2) 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.

(3) Other limitations include the following:

(a) 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.

(b) PCA services shall not include tasks usually performed by chore aides or homemakers, such as cleaning of areas not occupied by the recipient, laundry for family members, shopping for items not used by the recipient, or money management.

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

(d) A waiver beneficiary may receive PCA and adult day health services (Waiver or State Plan) on the same day, so long as these services are not provided at the same time nor billed concurrently.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care Aide

Provider Category:

Agency

Provider Type:

Home 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;
- 2) Have a current Medicaid provider agreement on file with DHCF as an enrolled EPD Waiver provider before providing any waiver services;
- 3) All Personal Care Aides shall have the same qualification and standards as established under the Medicaid State Plan including certification under Chapter 93 of Title 17 of the DCMR; and
- 4) Home Care Agencies providing personal care aide services under the EPD Waiver shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.

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 compliance with EPD Waiver programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Contracted D-SNPs must enroll and credential qualified EPD waiver providers, and must ensure that all qualified waiver providers are known to DHCF.

Frequency of Verification:

DHCF’s Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements 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-validation process once every three (3) years. DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Contracted D-SNPs shall verify provider qualifications no less frequently than once every three (3) years, and in accordance with requirements of plan accreditation and DHCF oversight.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09011 respite, out-of-home

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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.

Respite is usually provided in a person's home. However, Federal financial participation is not to be claimed for the cost of room and board except when respite is provided as part of respite care furnished in a facility approved by the State that is not a private residence, including an Assisted Living facility, Medicaid enrolled group home, or other community care residential 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 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 in accordance with dietary guidelines and other cultural/religious dietary restrictions, and assistance with eating;
- d. Household tasks related to keeping the recipient's living areas in a condition that promotes the recipient's health, comfort, and safety; and
- e. Accompanying the recipient to medically related appointments.

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

- 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 care on an ongoing basis. Respite services are only available to beneficiaries who have a live-in, unpaid caregiver (non-PCA). Respite services are available for beneficiaries' unpaid caregivers (non-PCAs) for a maximum of 480 hours per waiver certification period for hours that are not otherwise staffed by a personal care aide. DHCF will make exceptions to provide respite services to beneficiaries whose unpaid primary caregivers are not living with them.
- 4) Respite services are limited to a maximum of seventeen (17) hours per day, and a maximum of four hundred and eighty (480) hours per year. Requests 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.
- 6) If respite care is provided in a facility other than a person's residence, the facility must meet all the setting requirements under 42 CFR 441.301 and be enrolled as a Medicaid provider of respite services.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency
Agency	Facility enrolled to provide respite services

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Home 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.
- 3) 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 (b) employed by the home care agency. A copy of the initial intake assessment must be on file with the home care agency.
- 4) The initial intake assessment conducted by the RN 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 at least 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.
- 6) Home Care Agencies providing respite services under the EPD Waiver shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.

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 compliance with EPD Waiver programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Contracted D-SNPs must enroll and credential qualified EPD waiver providers, and must ensure that all qualified waiver providers are known to DHCF.

Frequency of Verification:

DHCF’s Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements 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-validation process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Contracted D-SNPs shall verify provider qualifications no less frequently than once every five (5) years, and in accordance with requirements of plan accreditation and DHCF oversight.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Facility enrolled to provide respite services

Provider Qualifications

License (specify):

Requisite license as an Assisted Living Facility, community residential facility or group home.

Certificate (specify):

Other Standard (specify):

The facility must have a reserved number of beds for respite.
Must be enrolled as a respite provider under DHCF's EPD Waiver program.

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 compliance with EPD Waiver programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Contracted D-SNPs must enroll and credential qualified EPD waiver providers, and must ensure that all qualified waiver providers are known to DHCF.

Frequency of Verification:

DHCF’s Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements 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-validation process (every three years). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Contracted D-SNPs shall verify provider qualifications no less frequently than once every five (5) years, and in accordance with requirements of plan accreditation and DHCF oversight.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assisted Living

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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, coordinating transportation to community-based events, and medication assistance provided by a Registered Nurse (RN) or Certified Medication Aide (MA-C) in accordance with District regulations. Services that are provided by third parties must be coordinated with the assisted living provider.

The reimbursement rate for Assisted Living facilities does not include transportation costs. Assisted Living providers are responsible for coordinating transportation to any off-site visits through the Non-Emergency Medical Transportation (NEMT) benefit, whether under Medicaid fee-for-service or D-SNP coverage.

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

EPD wavier assisted living services do not include housing or meals. Assisted living services are reimbursed through a bundled, per diem rate. The per diem payment does not include, nor will additional payment be made for, 24-hour skilled care or skilled supervision; room and board; costs of facility maintenance; or upkeep and improvement. DHCF does not reimburse for PCA services provided to waiver participants residing in assisted living facilities, as the provision of these services is already accounted for in District Medicaid's assisted living per diem reimbursement rate.

A provider will not be reimbursed for assisted living services if they do not meet the settings 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

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living Facility

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assisted Living

Provider Category:

Agency

Provider Type:

Assisted Living Facility

Provider Qualifications

License *(specify):*

Facility must be licensed by the District of Columbia Health Regulation and Licensing 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*):

- 1) Have a Medicaid Provider Agreement and be enrolled as an EPD Waiver Provider;
- 2) Be in compliance with the Assisted Living Resident Regulatory Act of 2000 (DC St. §§ 44-101.01 et seq.), and Chapter 34 of Title -22 B of the DCMR; and
- 3) Assisted Living service Providers shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supported Community Integration, and any other topics as determined by DHCF.

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 compliance with programmatic requirements. 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.

Contracted D-SNPs must enroll and credential qualified EPD waiver providers, and must ensure that all qualified waiver providers are known to DHCF.

Frequency of Verification:

- 1) DHCF's Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements at least annually.
- 2) DHCF Division of Public and Private Provider Services verifies qualifications during the initial provider application review process as well as the re-validation process once every five (5) years. DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.
- 3) DC Health verifies upon review and approval of initial license and every year.

Contracted D-SNPs shall verify provider qualifications no less frequently than once every five (5) years, and in accordance with requirements of plan accreditation and DHCF oversight.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Other Service

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

Service Title:

Chore Aide

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08060 chore

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Chore Aide services consist of heavy household 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 providers' safe entry and exit. Ideally, the chore aide prepares the home environment to be safe and clean and to facilitate more routine and ongoing 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) per person for the five year waiver period. 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 homes.

Chore aide services are provided only in cases where the person receiving services, other household residents, the person’s landlord, or a third party payor is neither able nor responsible for providing the service under a lease or other agreement.

Chore aide tasks must be performed in accordance with a PCSP. 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 PCSP. 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.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed provider of chore aide services
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Chore Aide

Provider Category:

Agency

Provider Type:

Licensed provider of chore aide services

Provider Qualifications

License (specify):

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):

N/A

Other Standard (specify):

- 1) Be enrolled as an EPD waiver Provider of Chore Aide Services; and
- 2) Have a current Medicaid provider agreement on file with DHCF before providing any waiver services; and
- 3) Providers must have bylaws or similar documents regulating conduct and internal affairs via established Policies and Procedures;
- 4) Individual Chore Aide worker standards are as follows:
 - (a) If employed by a home care agency, be certified as a Home Health Aide in accordance with Chapter 93 of Title 17 of the District of Columbia Municipal Regulations; or
 - (b) If employed by a business licensed to perform housekeeping services, obtain a minimum of eight (8) hours of training annually in the following areas:
 1. Residents Rights;
 2. Communicating effectively with persons enrolled in the waiver;
 3. Preventing Abuse, Neglect and Exploitation;
 4. Controlling the spread of disease and infection;
 5. Changing linens and bed bug prevention;
 6. Safe handling of cleaning chemicals (use of gloves, goggles/masks);
 7. Handling hazardous waste;
 8. Blood-borne pathogens and bodily fluids; and
 9. Instructions on the following-
 - a. Maintenance of floors (mopping/vacuuming)
 - b. Trash handling
 - c. Cleaning Walls and ceiling
 - d. Kitchen/Bathroom cleaning/maintenance
 - (c) Chore aides must be 18 years of age and pass a criminal background check
 - (d) 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; and
and
- 6) Home Care Agencies providing chore aide services under the EPD Waiver shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics as determined by DHCF.

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 compliance with EPD Waiver programmatic requirements . Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Contracted D-SNPs must enroll and credential qualified EPD waiver providers, and must ensure that all qualified waiver providers are known to DHCF.

Frequency of Verification:

DHCF's Long Term Care Administration will monitor providers to ensure compliance with EPD Waiver programmatic requirements 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). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Contracted D-SNPs shall verify provider qualifications no less frequently than once every five (5) years, and in accordance with requirements of plan accreditation and DHCF oversight.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Chore Aide

Provider Category:

Agency

Provider Type:

Home 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*):

N/A

Other Standard (*specify*):

- 1) If enrolled as a home care agency, also 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;
- 2) Be enrolled as an EPD waiver Provider of Chore Aide Services;
- 3) Have a current Medicaid provider agreement on file with DHCF before providing any waiver services; and
- 4) Providers must have bylaws or similar documents regulating conduct and internal affairs via established Policies and Procedures.
- 5) Individual Chore Aide worker standards are as follows:
 - (a) If employed by a home care agency, be certified as a Home Health Aide in accordance with Chapter 93 of Title 17 of the District of Columbia Municipal Regulations;
 - (b) Chore aides must be 18 years of age and pass a criminal background check
 - (c) Chore services must include a pre- and post-cleaning inspection of the home by the Home Care Agency, 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.
 - (6) Home care agency providers of chore aide services shall complete mandatory training in Person-Centered Thinking, Supported Decision-Making, Supported Community Integration, and any other topics as determined by DHCF.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCF Division of Public and Private Provider Services will conduct an initial provider screening to ensure that provider qualifications are met. Additionally, once provider qualifications are verified, DHCF’s Long Term Care Administration (LTCA) will conduct a provider readiness review. The provider readiness review will include an unscheduled on-site visit to ensure that the elements of the Provider Readiness Review are in place.

Contracted D-SNPs must enroll and credential qualified EPD waiver providers, and must ensure that all qualified waiver providers are known to DHCF.

Frequency of Verification:

DHCF’s LTCA and DHCF’s Division of Public and Private Provider Services will verify provider readiness during initial provider application review process as well as the re-validation process once every three (3) years.

Contracted D-SNPs shall verify provider qualifications no less frequently than once every three (3) years, and in accordance with requirements of plan accreditation and DHCF oversight.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition Services

HCBS Taxonomy:

Category 1:

16 Community Transition Services

Sub-Category 1:

16010 community transition services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institution or other long-term care facility to a more integrated and less restrictive community setting. Allowable expenses are those necessary to enable an individual to establish a basic household that does not constitute room and board and may include:

- (a) application fees and security deposits in the amount of the first month’s rent or greater that are required to obtain a lease on an apartment or home;
- (b) essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
- (e) moving expenses;
- (f) necessary home accessibility adaptations; and
- (g) activities to assess need, arrange for and procure needed resources.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the transition planning process, and clearly identified in the individual’s transition plan or PCSP once they are enrolled in the EPD Waiver.

DHCF or its designee, and Case Managers shall coordinate community transitional supports while an individual is an inpatient in an institution or long-term care facility. Once the individual has enrolled in the EPD Waiver and transitions into the community Case Managers shall coordinate transitional community supports for a period not to exceed six months from the date of discharge into the community. A Financial Management Services Support Broker will be responsible for procuring services and goods on behalf of the individual.

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

Community Transition Services (CTS) up to an amount of five thousand dollars (\$5,000) may be used as determined in the transition plan development. An individual is eligible for CTS from the time a tentative discharge date has been established for no more than sixty (60) days prior to, and up to six (6) months following, discharge from an institution or long-term care facility. The individual must be enrolled in the waiver prior to the submission of a bill for reimbursement for covered CTS.

Community Transition Services do not include monthly rental or mortgage expenses; food, including pantry set-up; regular utility charges; household appliances or items that are intended purely for recreational purposes; environmental accessibility adaptations services that are of direct medical or remedial benefit to the person; and/or any durable medical equipment when these services and equipment are covered by a service other than Community Transition Services.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Agency

Provider Type:

Case Management Agency

Provider Qualifications

License (specify):

Any relevant license referenced under the Case Management Service Description in Appendix C

Certificate (specify):

N/A

Other Standard (specify):

Any relevant standards referenced under the Case Management Service Description in Appendix C

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 compliance with EPD Waiver programmatic requirements. 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 monitor providers to ensure compliance with EPD Waiver programmatic requirements 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-validation process (every three years).

DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Contracted D-SNPs shall verify provider qualifications no less frequently than once every five (5) years, and in accordance with requirements of plan accreditation and DHCF oversight.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

DSNP/Managed Care Capitated Waiver Services

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DSNP/Managed Care Organization

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: DSNP/Managed Care Capitated Waiver Services

Provider Category:

Agency

Provider Type:

DSNP/Managed Care Organization

Provider Qualifications

License (specify):

DSNP/Managed Care Organizations are licensed in accordance with District regulations and deliver services in accordance with requirements set by CMS/DHCF.

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCF

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environment Accessibility and Adaptation Services

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

EAA is comprises those physical adaptations to the private residence of the person or the person’s family, required by the person's PCSP, 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. The waiver case manager or D-SNP ICT 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 or ICT. Renters will be exempt from proving ineligibility for HAIP.

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 or ICT) 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. Case Managers or ICTs will only contact landlords with the permission of the person receiving services.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Third Party Construction Inspector; Licensed Contractor; or Licensed Building Contractor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environment Accessibility and Adaptation Services

Provider Category:

Individual

Provider Type:

Certified Third Party Construction Inspector; Licensed Contractor; or Licensed Building Contractor

Provider 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):

- 1) 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.
- 2) Contractors must be enrolled as an EPD Waiver provider.

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 compliance with programmatic requirements. Additionally, provider qualifications are reviewed and verified by DHCF Division of Public and Private Provider Services.

Contracted D-SNPs must enroll and credential qualified EPD waiver providers, and must ensure that all qualified waiver providers are known to DHCF.

Frequency of Verification:

DHCF's Long Term Care Administration will monitor programmatic requirements 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). DHCF may conduct telephonic surveys in lieu of out-of-State site visits for prospective EPD Waiver Medicaid provider applicants (and/or re-enrolling providers) to verify provider readiness.

Contracted D-SNPs shall verify provider qualifications no less frequently than once every five (5) years, and in accordance with requirements of plan accreditation and DHCF oversight.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual Directed Goods and Services

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

IDGS includes 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 service plan (PCSP) (including improving and maintaining the individual’s opportunities for full membership in the community) and meet the following requirements. The item or service would:

- o Decrease the need for other Medicaid services; and/or
- o Promote inclusion in the community; and/or
- o Increase the waiver participant’s safety in the home environment.

The following items/services may be approved:

- o Small electric appliances without which the participant cannot safely prepare meals; and
- o Maintenance of items that meet the criteria of allowable individual-directed good above.

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 otherwise 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 service plan and approved by DHCF.

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

Waiver participants who elect the Services My Way program may purchase individual-directed goods and services that are included in their PCSP, meet the criteria listed above and are within the means of their PDS budget to purchase. Support brokers help participants revise and manage their PDS budgets, as necessary, to account for new, appropriate individual-directed goods and services they would like to purchase.

For fee-for-service waiver participants, upon revising a PDS budget to reflect a new individual-directed good or service, the support broker submits the revised PDS budget to DHCF. DHCF reviews all requested individual-directed goods and services, and either approves or denies the requested item. Upon approval, DHCF will submit the amended PDS budget to the Vendor Fiscal/Employer Agent (VF/EA) Financial Management Services (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.

For waiver participants enrolled in a contracted D-SNP, the D-SNP will review and either approve or deny all IDGS requests submitted by PDS participants and their care teams through standardized benefit determination and authorization processes. DHCF will review and monitor the D-SNPs' policies and procedures for, and utilization of, IDGS in accordance with its oversight obligations for the EPD Waiver program.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual/Vendor as selected by the participant

Appendix C: Participant Services

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

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 eighteen (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 drivers 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 or a contracted D-SNP on behalf of DHCF.

Verification of Provider Qualifications

Entity Responsible for Verification:

VF/EA FMS-Support Broker entity or contracted D-SNPs.

Frequency of Verification:

At time of enrollment and thereafter as necessary.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Participant-Directed Community Support Services

HCBS Taxonomy:

Category 1:

12 Services Supporting Self-Direction

Sub-Category 1:

12010 financial management services in support of self-direction

Category 2:

12 Services Supporting Self-Direction

Sub-Category 2:

12020 information and assistance in support of self-direction

Category 3:

17 Other Services

Sub-Category 3:

17010 goods and services

Service Definition (*Scope*):**Category 4:****Sub-Category 4:**

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 service plan (PCSP) 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 are available to assist the participant/representative-employer with employer-related responsibilities through the VF/EA FMS-Support Broker entity.

Allowable tasks performed by a PDW include cueing, safety monitoring, and hands-on assistance with activities of daily living and instrumental activities of daily living.

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. Payment will not be made to a PDW who is the participant's spouse, parent, or, if minor participant, legal guardian.

All PDCS services provided by a PDW must be prior authorized in order to participate in the Services My Way program.

- (1) PDCS services must be included in the participant's PCSP, and the participant must be in receipt of a service authorization for EPD Waiver services as established by an assessment determining the individual requires a nursing facility level of care.
- (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 by DHCF for PCA services rendered by a home health agency. Payment is dictated by the amount, duration, and scope of services determined in accordance with the participant's service authorization pursuant to the assessment and care planning activities conducted by DHCF or its agents.
- (3) An individual or family member other than the participant'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:
 - (a) 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.
 - (b) PDCS shall not include tasks usually performed by chore aider or homemakers, 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.
 - (c) 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 that includes PCA services as a reimbursed service.
 - (d) When a person is receiving PDCS and any adult day services (waiver or State Plan) on the same day, the combination of both PDCS and adult day services shall not exceed a total of sixteen (16) 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

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual, Participant-Directed Worker

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Participant-Directed Community Support Services

Provider Category:

Individual

Provider Type:

Individual, Participant-Directed Worker

Provider Qualifications

License (specify):

N/A

Certificate (specify):

NA

Other Standard (specify):

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

- Be at least eighteen (18) years of age;
- 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. Law 14-98; D.C. Official Code §§ 44-551 et seq.);
- Receive customized training provided by the participant and/or his/her authorized representative;
- Be able and willing to provide the service-related responsibilities outlined in the participant’s PCSP;
- Be certified in cardiopulmonary resuscitation (CPR) and First Aid through an in-person training course approved by the American Red Cross or an alternative course approved by the Services My Way Program Coordinator and maintain current certifications;
- Not be a participant in the Services My Way program;
- Have an individual NPI number obtained from the National Plan and Provider Enumeration System (NPPES); and
- Must register NPI number and complete application for PDWs in the Provider Data Management System (PDMS).

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 or contracted D-SNP 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 verifies that PDW qualifications are met during the employment process and executes a Medicaid provider agreement with each PDW on behalf of DHCF.

Appendix C: Participant Services

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

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

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

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

Check each that applies:

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

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

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

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

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

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

For fee-for-service waiver participants, all case management services are furnished by Medicaid-enrolled case management agencies. For waiver participants enrolled in a D-SNP, the participant's interdisciplinary care team (ICT) under the D-SNP furnishes waiver case management services as a component of comprehensive care management.

Under both delivery systems, case management services include direct observation of the participant, initial comprehensive assessment of the participant's medical, social, and functional status to include obtainment of level of care determinations, determining, developing, implementing, and monitoring the participant's comprehensive person-centered service plan (PCSP)--which for D-SNP enrollees is then incorporated into their D-SNP Individualized Care Plan (ICP)--and coordination of annual or ad hoc reassessment in the event of significant changes in the participant's health care needs.

Appendix C: Participant Services

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

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

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

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

(a) All direct care individuals and providers including personal care aides, attendants, and respite care providers must undergo criminal background checks. Case managers are licensed professionals, who are required to get a criminal background check per the District's licensing laws.

(b) The scope of investigations includes a criminal background check at the District level (state level).

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

DHCF and its contracted D-SNPs are responsible for oversight and monitoring to ensure compliance with background check requirements. For providers enrolled directly with the Medicaid fee-for-service program, DHCF reviews a sample of all personnel records to monitor compliance. For providers enrolled with the D-SNPs to provide waiver services who do not provide fee-for-service EPD waiver services, DHCF requires reporting from its D-SNPs regarding their monitoring and oversight of provider compliance.

The District requires that all individuals rendering case management services, through either enrolled case management agencies or contracted D-SNPs, are licensed health professionals. Staff providing conflict-free case management services must have a current appropriate licensure as a Health Professional (e.g., Nursing, Social work, Psychology, Counseling, Occupational therapy, Physical Therapy, or Speech Therapy).

As part of obtaining and maintaining a license in the District, all health professionals must undergo a criminal background check at the time of obtaining a license and upon renewal of license pursuant to the "Licensed Health Professional Criminal Background Check Amendment Act of 2006", effective March 6, 2007, (D.C. Law 16-222, D.C. Official Code § 3-1205.22 et seq.).

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

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

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

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Individual Directed Goods and Services	
Case Management	
Adult Day Health	
Chore Aide	
DSNP/Managed Care Capitated Waiver Services	
Assisted Living	
Community Transition Services	
Participant-Directed Community Support Services	
Homemaker	
Personal Care Aide	
Respite	
Environment Accessibility and Adaptation Services	

Facility Capacity Limit:

The size of each facility shall be governed by the Assisted Living regulations, as designated/approved by the Licensing division.

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

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	

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

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

The Assisted Living Residence Regulatory Act of 2000 does not speak specifically to ratios but states that an Assisted Living Residence (ALR) employ staff and develop a staffing plan in accordance with the act and based upon the following criteria:

- (A) The health, mental condition, and psycho-social needs of the residents;
- (B) The fulfillment of the 24-hours-a-day scheduled and unscheduled needs of the residents;
- (C) The size and layout of the ALR;
- (D) The capabilities and training of the employees; and
- (E) Compliance with all of the minimum standards in this act; to assure the safety and proper care of residents in the Assisted Living Residence.

EXPLANATION OF HOW HEALTH AND WELFARE OF PARTICIPANTS IS ASSURED IN THE STANDARD FOR INCIDENT REPORTING

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

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

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

Appendix C: Participant Services

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

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

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

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

(a) The District does make payments to legally responsible individuals for furnishing personal care aide, or similar services (respite, chore aide) for individuals who do not self-direct. Some family members may also receive compensation for PCA or similar services. According to the rules, a waiver recipient may choose an individual or a family member other than a spouse, or parent of a minor recipient, or other legally responsible relative to provide PCA or similar services (chore aide, respite). However, parents of adult recipients, legally responsible or otherwise, may provide PCA or similar services. All legally responsible persons or relatives must obtain the same training requirements as other personal care aides, chore aides, or respite staff.

For example, a legally responsible person or relative providing PCA services shall meet the following requirements:

1. Be at least 18 years of age.
2. Be a citizen of the US or lawfully authorized to work in the US.
3. Complete a home health aide training program which includes at least 75 hours of classroom training, with at least 16 hours devoted to supervised practical training, and pass a competency evaluation for those services which the PCA is required to perform, consistent with the requirements set forth in 42 CFR 484.36, and provide a copy of the certificate and competency evaluations.
4. Be certified in cardiopulmonary resuscitation (CPR) and obtain CPR certification annually.
5. Be able to read and write the English language at a 5th grade level and carry out instructions and directions.
6. Be able to recognize an emergency and be knowledgeable about emergency procedures.
7. Be knowledgeable about infection control procedures.
8. Be acceptable to the recipient and not be a spouse, parent of a minor recipient, or other legally responsible relative.
9. Demonstrate annually following the Centers for Disease Control guidelines that s/he is free from communicable disease, as confirmed by a chest x-ray or by an annual Purified Protein Derivative (PPD) Skin Test or documentation from a physician stating that the person is free from communicable disease.
10. Pass a criminal background check pursuant to the Health Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999, DC Law 12-238.
11. Provide documentation of acceptance or declination of the Hepatitis vaccine.
12. Be supervised by a registered nurse.

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

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

(c) The controls employed to ensure that payments are only made for services rendered include PCA service limitations. The limitations on the amount of PCA services for which payment may be made shall not exceed sixteen (16) hours per day, up to seven (7) days per week. Additional limitations include: PCA services shall not include the requirement of a skilled licensed professional; shall not include tasks performed by chore aides; shall be available seven (7) days per week; shall be provided at place of employment, in transit, and in residence; and shall not be reimbursed if provided in a hospital, nursing facility, intermediate care facility, institution for mental disease, or assisted living facility.

When different services are rendered by two employees from the same agency, all RN visits shall be coordinated so

that the supervisory in-home RN visits are in accordance with waiver standards and supervisory RN visits are made by the same supervising RN at the same time.

Similarly, when a legally responsible individuals or family member provides other similar services (i.e., respite, chore aide, or homemaker services), they must obtain the same provider qualification/training as specified in the requisite Provider Qualification sections under Appendix C.

Self-directed

Agency-operated

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

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

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

The State will allow payments to be made to relatives/legal guardians under special circumstances.

The following applies to adult day health, EAA, and Assisted Living waiver services: The District enrolls provider entities and not professionals directly. DHCF does not prohibit payment to waiver participants' relatives/legal guardians who are hired by the entities and does not prohibit a relative/legal guardian's own provider entity from being enrolled as a Medicaid provider. Medicaid payments are made to the enrolled provider entity.

The case manager or D-SNP ICT, through the person-centered planning process, assists the individual and responsible party to plan the services that reflect the individual's personal preferences, choices and safeguards their health and welfare. Additionally, the case managers or D-SNP ICT ensure that the individual is receiving services in accordance with the PCSP throughout the Waiver year and especially during the face-to-face monthly monitoring visits. It is often times during these visits, along with the quarterly PCSP reviews, that the case managers or D-SNP ICT can determine whether services are or are not provided in the best interest of the person. If a case manager suspects that services are not provided in the best interests of the beneficiary, they can report the finding to DHCF's LTCA for review and guidance by DHCF's Office of the General Counsel. Case managers or D-SNP ICTs are also required to report instance of abuse or neglect to Adult Protective Services. Additionally, the LTCA's oversight and monitoring unit randomly reviews cases where the legal guardian provides services to ensure that services are being provided in accordance with the PCSP. Case Managers or D-SNP ICTs plan services through the person-centered planning process and the PCSP identifies goals and related services. The PCSP is reviewed by DHCF or its designee for issuing the prior-authorization for the services. Case managers or D-SNP ICTs conduct monthly visit to ensure that services are furnished and addressing the person's needs. If service deficiencies are noted, case managers or D-SNP ICTs identify and resolve them. If service change is needed, the PCSP is amended to reflect the changes. Additionally, DHCF's oversight and monitoring Division reviews randomly selected cases on a quarterly basis to ensure that services were rendered in accordance with the PCSP and in the best interest of the individual. Discovery/remediation is generated for deficiencies identified and followed upon until issue resolution. The cases that are suspected of fraud are referred to DHCF's Program Integrity Division for further review and audit.

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

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

Other policy.

Specify:

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

ENROLLMENT OF FEE-FOR-SERVICE EPD WAIVER PROVIDERS

The following processes are used to assure that all willing and qualified providers have the opportunity to enroll as fee-for-service Waiver providers. All qualified Waiver providers are accepted as providers of care. All criteria for Waiver providers are available to any and all interested providers. This information is available online at www.dc-medicaid.com and www.dhcf.dc.gov, as well as provided on an ad hoc basis through technical assistant provided to prospective Waiver providers by DHCF staff.

The Readiness Process is initiated by the prospective provider submitting a letter of interest (LOI) to DHCF expressing an interest in becoming an EPD Waiver provider. The LOI is submitted via email and instructions regarding the LOI are maintained on DHCF's website. The letter of interest must include the following:

- Name of the agency with proof of current incorporation in the District of Columbia;
- Contact person with a postal mailing address, business email address and telephone number;
- A brief description of the type of services they would like to provide; and
- A brief statement of the agency's readiness to provide the service(s) for which approval is requested. The statement must provide evidence of knowledge and understanding of the relationship between State Plan and Waiver service as related to the service provision(s) for which the applicant is seeking approval.

Within ten business days of the receipt of a letter of interest from a prospective provider, DHCF will respond to the prospective provider via email and provide an overview of the readiness process including a contact person for technical assistance and information on attending a mandatory prospective provider information session.

The prospective provider is required to attend an information session coordinated by DHCF. An application for enrollment as an EPD waiver provider must be submitted within sixty (60) business days of the date of attendance at the prospective provider information session.

DHCF anticipates processing applications for EPD Waiver providers within thirty (30) business days of receipt of a complete application packet.

The application should include, but is not limited to the following: A description of ownership and a list of major owners, a list of Board members and their affiliations, a roster of key personnel, their qualifications and a copy of their positions descriptions, copies of licenses and certifications for all staff providing medical services, the address of all sites at which services will be provided to Medicaid participant, copy of the most recent audited financial statement of the organization, a completed copy of the basic organizational documents of the provider, a detailed organizational chart including all current employees, current articles of the incorporation, copy of the by-laws or similar documents regulating conduct of the provider's internal affairs, copy of the business license, and the submission of any other documentation deemed necessary by DHCF to determine the provider's ability to comply with Waiver requirements and deliver Waiver services.

Provider applications are submitted through DHCF's electronic provider data management system and its provider enrollment vendor, who in turn scans the application and submits the document to DHCF.

DHCF preliminarily reviews the application in accordance with Federal and District screening requirements. This includes verification of the submission of the disclosure of ownership form, NPI/Taxonomy Code, liability insurance, surety bond (applicable to those providers rendering PCA services), and verification against Federal exclusion databases.

After this initial review, additional review will evaluate organizational policies and procedures as well as the organization's business plan and financial documents.

Incomplete applications submitted to DHCF will be returned within fifteen (15) days of receipt; applicants have ten (10) business days to provide DHCF with all requested information/documentation. If the information/documentation is not provided to DHCF within ten (10) business days, the application is then formally returned to the prospective provider as a denial. The provider is welcome to reapply at any time in the future.

Each application component must be satisfactory before the prospective provider can be considered qualified. If the applicant fails to successfully satisfy any of the components, the application will be returned and the applicant may reapply. Subsequent to a formal denial of an application, each resubmission requires attendance at a Prospective Provider Information Session no more than sixty (60) days prior to the application (re)submission date.

If the application is approved, the provider must respond to a request for criminal background checks/fingerprints for all of the names listed on the disclosure of ownership form. They have 30 days from the date of the letter to respond. If no response is provided, the application is denied. If they respond on a timely basis and there are no deficiencies, then they will be notified of a request to attend the Mandatory Provider orientation conducted by the District's fiscal agent for training on programmatic and billing procedures. Once the provider attends the provider orientation, then DHCF or its agent will sign the provider agreement, assign a DC Medicaid provider number and issue a Welcome Letter to the provider.

ENROLLMENT OF EPD WAIVER PROVIDERS BY CONTRACTED D-SNPS

Qualified EPD Waiver providers may also be enrolled by integrated health plans offering Medicare and Medicaid coverage as a D-SNP contracted with DHCF. Such providers must be credentialed by such a health plan prior to delivering Waiver services.

Contracted D-SNPs shall develop and maintain written policies and procedures for credentialing and re-credentialing EPD Waiver providers to ensure EPD Waiver services are provided by appropriately licensed and accredited Providers. These policies and procedures shall, at a minimum, comply with NCQA standards, and are subject to review and approval by DHCF. Contracted D-SNPs shall maintain a documented re-credentialing process for Waiver providers which shall take into consideration various forms of data including, but not limited to, grievances, results of quality reviews, UM information, and Enrollee satisfaction surveys.

Contracted D-SNPs shall have written policies and procedures, subject to review and approval by DHCF, for monitoring Waiver providers and for sanctioning Providers who are out of compliance with the Contractor's quality of care standards or have been excluded, suspended or debarred from participating in any District, state, or Federal health care benefit program.

Upon written notice from DHCF, Contracted D-SNPs shall not authorize any Waiver providers terminated or suspended from Medicaid participation to treat Waiver participants, and the Contractor shall deny payment to such Providers for services provided after the Contractor notified the Provider.

Contracted D-SNPs shall maintain provider credentialing files, to include data regarding EPD Waiver providers, that shall include but not be limited to: Licensure status; Professional affiliations; Education and training; Professional credentials and/or certifications; Basic demographic information; Hours of operations; Office locations; Languages spoken by office staff; Status of panel (open, closed); Satisfaction Survey responses; Reported incidents; Documentation that the Provider has not been suspended, excluded or debarred from participation in any District, state, and/or Federal health care benefit programs; and documentation that Providers have completed all training modules required by DHCF or the Contractor.

Contracted D-SNPs shall report to DHCF any changes in an EPD Waiver provider's credentialing information, including the Contractor's refusal to credential or re-credential such a provider.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

(6) C.c.1 Percentage of enrolled waiver providers by type who continue to meet EPD Waiver Qualifications. Numerator = Number of enrolled waiver providers by type who continue to meet EPD Waiver Qualifications. Denominator = Number of enrolled waiver providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Health and Regulation and Licensing Administration (HRLA) Spreadsheet

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="HRLA; Contracted D-SNPs"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>

	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text" value="Contracted D-SNPs"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

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

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

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

Performance Measure:

(7) C.c.1 Percentage of newly enrolled waiver providers that meet provider readiness. Numerator = Number of newly enrolled waiver providers that meet provider readiness. Denominator = Number of newly enrolled waiver providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Program Operations Spreadsheet

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Contracted D-SNPs	
	Continuously and Ongoing
	Other Specify:

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

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

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

Performance Measure:

(8) C.c.1 Percentage of providers that train staff according to DHCF EPD waiver policies and procedures. Numerator= Number of waiver providers that meet all training indicators on the Provider annual monitoring audit. Denominator= Number of waiver providers reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		Confidence Level 95 / Error rate 10 Confidence Level 90 / Error rate 10 Confidence Level 90 / Error rate 15 Confidence Level 90 / Error rate 20
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>

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

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

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

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

The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF.

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

The DQHO partners with LTCA conduct comprehensive review for assessing the overall performance of the EPD Waiver. It includes an iterative process for assessing performance, identify opportunities for improvement and outline recommendations for targeted quality improvement processes and measuring and monitoring the program's overall effectiveness. Additionally, all applicable providers shall be subject to quality standards , including but not limited to, guidance issued by the Centers for Medicare and Medicaid Services (CMS) and rules issued by DHCF's quality improvement activities.

There are two different types of reviews. One review (used for this performance measure) is the program monitoring audit which is an annual review and includes 100% of the providers. The audits performed for the performance measures in Appendix I-1 are program integrity audits and are conducted quarterly on a sample of claims.

There is 100% review of all providers and each provider is required to do 100% training of all employees. In DHCF’s review we select a random sample of the employee records to review to ensure compliance. Consumer Direct, our vendor for PDS, does 100% review for participant directed workers and DHCF does a sample as stated above. This is part of the annual monitoring referenced in Appendix D-2-a.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

In order to qualify for Medicaid reimbursement, EPD Waiver Providers shall comply with programmatic requirements as part of its Provider Readiness Review and enrollment. The programmatic requirements include adherence to acceptable standards in the following areas:

- (1) Service Delivery as governed by the provider requirements and duties established under Appendix C's- Service Description Section;
- (2) Program administration as governed under mandated policies and procedures;
- (3) EPD Waiver-related Performance Measures;
- (4) Staffing and training; and
- (5) Home and Community Based Services (HCBS) setting requirements.

DHCF may impose alternative sanctions against an EPD Waiver provider:

- (1) In response to a complaint;
- (2) In response to an incident report;
- (3) Upon recommendation by DHCF's Division of Program Integrity; or
- (4) Upon recommendation by DHCF's LTCA EPD Waiver Monitoring Unit.

DHCF shall determine the appropriateness of alternative sanctions based on the following factors:

- (1) Seriousness of the violation (s);
- (2) Number and nature of the violations(s);
- (3) History of prior violations(s);
- (4) Potential for serious harm to beneficiaries;
- (5) Recommendation(s) by DHCF's Division of Program Integrity or LTCA EPD Waiver Monitoring Unit; or
- (6) Other relevant factors.

DHCF may impose one or more of the following alternative sanctions if the violation does not place the beneficiary's health or safety in immediate jeopardy:

- (1) Imposition of a correction action plan;
- (2) Imposition of a cap on enrollment;
- (3) Denial of new admissions;
- (4) Imposition of an enhanced monitoring plan;
- (5) Withholding of provider reimbursements; or
- (6) Temporary suspension of the provider from participation in the EPD Waiver program.

DHCF shall publish rules which set forth the process and procedures governing the imposition of alternative sanctions.

DHCF reserves the right to terminate the provider agreement in accordance with the requirements set forth in Chapter 13 of Title 29 DCMR if the agency determines that alternative sanctions are inappropriate.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">Contracted D-SNPs</div>	Annually

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

No

Yes

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

As mentioned in question ii (Methods for Discovery), DHCF has in place several mechanisms to monitor and analyze EPD waiver performance. The LTCA Oversight and Monitoring Division conducts compliance reviews on performance measures of all waiver assurances. The LTCA Oversight and Monitoring Division is responsible for the discovery and remediation process of individual and systemic issues.

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

Performance measures are derived from the actual EPD waiver measures approved by CMS or other measures that the program feels are important to monitor. A report card of measures is maintained in the DQHO. The EPD staff submits performance rates to DQHO for tracking and trending. Once performance measure rates are submitted to the DQHO, an analysis is completed on individual performance measures and overall program performance. The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF.

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

The DQHO partners with LTCA conduct comprehensive review for assessing the overall performance of the EPD Waiver. It includes an iterative process for assessing performance, identify opportunities for improvement and outline recommendations for targeted quality improvement processes and measuring and monitoring the program's overall effectiveness. Additionally, all applicable providers shall be subject to quality standards, including but not limited to, guidance issued by the Centers for Medicare and Medicaid Services (CMS) and rules issued by DHCF's quality improvement activities.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

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

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

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

Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

future.

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

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

The District's HCBS Statewide Transition Plan was approved by CMS on September 29, 2017.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Elderly and Physical Disabilities Waiver

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

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

D-SNP Interdisciplinary Care Teams (ICTs) are responsible for development of the person-centered service plan (PCSP) for waiver participants enrolled in a contracted D-SNP. The PCSP for D-SNP enrolled waiver participants is then incorporated into their D-SNP Individualized Care Plan (ICP).

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The State will ensure that waiver participants (and/or family or legal representative, as appropriate) are supported to direct and actively engage in the development of their service plan.

During the development of the waiver participant's service plan, the waiver case manager or D-SNP ICT shall commit to making services fit individuals, rather than making individuals fit services, and enable a person-centered planning process, directed by the person (waiver participant) with long-term services and support needs (or a representative of their choosing), that meets the following requirements:

- o Occurs at a time and location that is convenient for the waiver participant and any other individuals the participant wants included in the planning;
- o Includes face-to-face discussions with the participant whose plan is being developed, other contributors chosen and invited by the participant, and representatives of the participant's interdisciplinary team, if possible;
- o Ensures that information shared with the participant is aligned to his/her acknowledged cultural preferences and communicated in a manner that ensures the participant and/or his/her representative understands the information; and
- o Embraces the personal preferences of the participant to develop goals and to meet the participant's needs.

At the outset of the service plan development process the waiver case manager or D-SNP ICT shall inform the participant (and/or family or legal representative, as appropriate) that he/she has the authority to include all individuals of his/her choosing to participate in the service planning and development process. The case manager or ICT shall ensure that the Person-Centered Service Plan (PCSP) development process is thoroughly explained and describes all support services available through the EPD Waiver and the larger Medicaid program that could assist the participant, as appropriate, to successfully and safely live in the community. Furthermore, the case manager or ICT explains the role of service provider agencies to the participant and provides him/her with the list of provider agencies that the participant can select from.

The case manager or ICT and the participant (and/or family or legal representative, as appropriate) shall discuss the participant's service needs and frequency with which each service will be provided, as well as select a provider agency to provide each service. Finally, the case manager or ICT shall inform the participant of his/her freedom of choice of providers during this initial meeting and at all subsequent meetings to include quarterly, mid-year and annual assessment and planning meetings, should a situation arise at any point which requires consideration of a provider change. The case manager or ICT also has the responsibility of ensuring that the freedom of choice of service and provider drives the planning process.

A standardized person-centered planning format is used throughout the planning development process for both fee-for-service waiver participants and waiver participants concurrently enrolled in a D-SNP. The PCSP is developed by the responsible waiver case manager or D-SNP ICT with the participant (and/or family or legal representative, as appropriate) along with a multidisciplinary team of individuals involved in the participant's care. These team members know and work with the participant and their active involvement is necessary to achieve the outcomes desired.

FEE-FOR-SERVICE PARTICIPANTS

For fee-for-service waiver participants, the District's Aging and Disability Resource Center (ADRC) works with newly enrolling participants to select and rank three preferred case management agencies (CMAs). During this initial interaction, the ADRC shares a list of CMAs so that the waiver participant is able to select and rank available CMA agencies. The ADRC reaches out to each CMA selected by the participant, and works to ensure that the participant is matched with his/her preferred CMA. If a CMA is unable to accept the participant, the ADRC will connect with the participant's next preferred CMA. Once the participant is determined eligible for and enrolled in the EPD waiver program, the ADRC conducts a 'warm' hand-off of the participant to the CMA, which includes developing notice/summary of all ADRC work with participant, services being received, etc. The selected CMA must contact the participant within 24 hours and use a person-centered approach to developing the participant's PCSP.

D-SNP PARTICIPANTS

For waiver participants concurrently enrolled in a D-SNP, the District will monitor and evaluate data on Interdisciplinary Care Teams (ICT) assignments and activities to ensure participants are able to exercise choice in their ICT supports.

Appendix D: Participant-Centered Planning and Service Delivery

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

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b)

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

WHO DEVELOPS THE PLAN, WHO PARTICIPATES IN THE PROCESS, AND THE TIMING OF THE PLAN

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

The case manager or ICT is responsible for developing the participant's service plan using a person-centered approach. Using this approach, the case manager or ICT ensures that the resulting person-centered service plan (PCSP) highlights the person's strengths and that it aligns with the participant's articulated quality of life goals, service and support needs, and preferences. The participant, as well as others that he/she chooses, are engaged in the development of the service plan. Additionally, the case manager or ICT must ensure that the process used to develop the participant's PCSP meets the following requirements:

1. Includes face-to-face discussions with the whose plan is being developed (waiver participant), other contributors chosen and invited by the participant, and representatives of the participant interdisciplinary team, if possible;
2. Incorporates feedback of members of the participant's interdisciplinary team and other key people chosen and invited by the participant;
3. Ensures that information shared with the participant is aligned to his/her acknowledged cultural preferences and communicated in a manner that ensures the participant 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> and all other applicable language access and cultural competence standards. If needed, auxiliary aids and services must be provided;
4. Provides meaningful access to participants and/or their representatives with limited English proficiency (LEP), including low literacy materials and interpreters;
5. Uses a strengths-based approach to identifying the positive attributes of the participant, including an assessment of the participant's strengths, preferences, and needs;
6. Embraces the personal preferences of the participant to develop goals and to meet the participant's needs;
7. Explores employment and housing in integrated settings, where planning is consistent with the participant's goals and preferences, including where the participant resides and who they live with; and
8. Ensures that participants 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.

TYPES OF ASSESSMENTS THAT ARE CONDUCTED TO SUPPORT THE SERVICE PLAN DEVELOPMENT PROCESS

Multiple assessments of the participant occur before the case manager or ICT develops the participant's PCSP. The assessments that occur prior to the service plan development occurs as follows:

All participants in the EPD Waiver program undergo a comprehensive assessment to ascertain the participant's required level of care as required for eligibility and enrollment in the waiver. This comprehensive assessment is conducted by DHCF's assessment vendor using the interRAI HC assessment tool and generates comprehensive information regarding the participant's health needs, services in place and services needed, personal preference, informal supports, and more. Any assigned waiver case management agency or ICT for the D-SNP in which a participant is enrolled has access to the comprehensive synthesis of health information yielded by the interRAI assessment.

The case manager or ICT conducts additional assessments, whether annually at the time of annual PCSP development or on an ongoing, as-needed basis. Such assessments may seek to establish the need for specific services (such as durable medical equipment or behavioral health supports) or they may elucidate changes in health status or changes in personal goals or preferences. Such assessments and evaluations impact the service planning process by informing the scope, delivery, and frequency of services and supports described in the participant's PCSP.

HOW THE PARTICIPANT IS INFORMED OF SERVICES AVAILABLE UNDER THE WAIVER

During a case manager's or ICT's initial contact with the participant, and others that the participant chooses to engage in the PCSP development process, the case manager or ICT provides information on services and supports available through Medicaid and non-Medicaid services, including supports from the person's family, friends, faith-based entities, recreation

centers, or other available community resources. D-SNP enrollees are counseled about the full spectrum of services available under the integrated program model.

Participants are again informed about each of these services during subsequent (reevaluation and interim changes) PCSP development and implementation processes and as often as needed should any circumstance arise that may warrant an interest in needing new services and/or changing providers. Also during the initial contact and at least annually, the case manager or ICT informs the participant that he/she can select any service provider he/she wants, including selecting a different provider for each service (if they choose to), without jeopardizing participation in the waiver. Furthermore, the case manager or ICT communicates with the participant that he/she can request a change in services and/or provider at any time.

Case managers and ICTs ensure that participants and/or their legal representatives understand their ability to select their services and providers so that the participant is able to document his/her Freedom of Choice related to choice between waiver services and institutional care, and choice between/among waiver services and providers (using standard documentation). On at least an annual basis, case managers and ICTs educate the participant on incidents such as abuse, neglect, and exploitation and provide information on how to report these incidents.

In addition, the case manager or ICT also provides the participant, others chosen by the participant, and/or his/her representatives with the web address for the Department of Health Care Finance (DHCF) website at: <http://dhcf.dc.gov> and the District of Columbia Office on Aging (DCOA) website at <http://www.dcoa.dc.gov>, where all of the waiver services are listed and informational materials regarding waiver services are posted.

HOW THE PLAN DEVELOPMENT PROCESS ENSURES THAT THE SERVICE PLAN ADDRESSES THE PARTICIPANT'S GOALS, NEEDS, AND PREFERENCES

The participant's PCSP must incorporate the following required components:

1. The participant's prioritized personal outcomes and specific strategies to achieve or maintain his/her desired personal outcomes, focusing first on informal and community supports and, if needed, paid formal services;
2. An action plan which will lead to the implementation of strategies to achieve the participant's identified desired personal outcomes, including action steps, review dates and timelines, and the responsible individual for each identified action, ensuring that the steps that are incorporated empower and enable the participant to develop independence, growth, and self-management;
3. Target dates for the achievement/maintenance of the participant's personal outcomes;
4. Identify the participant's preferred formal and informal service providers and specification of the service arrangements; and
5. Ensures the participant and individuals selected by the participant sign the service plan attesting to their agreement to participate in the implementation of the participant's plan and that the participant's goals, needs (including health care), and preferences are addressed.

HOW THE PLAN DEVELOPMENT PROCESS PROVIDES FOR THE ASSIGNMENT OF RESPONSIBILITIES TO IMPLEMENT AND MONITOR THE PLAN

The development of the participant's plan ensures that individuals selected by the participant to help create and participate in the implementation and monitoring of the participant's PCSP are identified, and that the roles and assigned responsibilities of these selected individuals are clear and understood. To confirm that those that have agreed to contribute to the participant's service plan understand their assigned responsibilities, the case manager or ICT shall ask that each such individual sign the PCSP.

The case manager or ICT monitors the activities and performance of those included in the participant's interdisciplinary team, including, but not limited to:

- RN: at set intervals and/or upon request of the participant, the case manager or ICT confirms that services requiring RN intervention (such as PCA services) are occurring and that their services are documented in clinical notes; and;
- Physician (or RN): shall review the participant's plan of care under which PCA services are delivered at least once every sixty (60) days, and shall update or modify the said plan of care as needed.

Furthermore, the case manager or ICT will assist with the coordination of all services including waiver and non-waiver services identified as a need to ensure that the assigned responsibilities facilitate the participant remaining in the community setting safely. The case manager or ICT will communicate with the selected direct care providers as well as

non-waiver service providers or resources to assess any changes in available support. The case manager or ICT will contact the participant, as well as others chosen by the participant, to evaluate the participant's satisfaction with the services received.

HOW AND WHEN THE PLAN IS UPDATED

The case manager or ICT shall work with the participant to implement the PCSP and ensure that the PCSP is updated at set time intervals, or more frequently if needed and/or requested by the participant.

Specifically, the case manager or ICT 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 participant's service plan, regardless of source of payment.
3. Monitor to ensure that needs and preferences are being met and that the participant receives services described in the participant's PCSP in type, scope, amount, duration, and frequency. If results of routine monitoring activities necessitate updates to the PCSP, this should be done within seven (7) days of said monitoring activity, with mandatory signatures of the participant and the case manager or ICT.
4. Review and update the PCSP at least every twelve (12) months or when the participant's functional needs change, circumstances change, quality of life goals change, or at the participant's request.
 - a. The case manager or ICT must respond to the participant's requests for updates within forty-eight (48) hours, with completion of the update within seven (7) days.
 - b. The updated PCSP must be done via face-to-face discussions with the participant whose plan is being developed, other contributors chosen and invited by the participant, and representatives of the participant's interdisciplinary team, as possible.
 - c. The updated PCSP must incorporate feedback of members of the participant's interdisciplinary team and other key individuals if and when they are unable to participate in face-to-face discussions inclusive of the participant.
 - d. The updated PCSP must include approval signatures of the participant and the case manager or ICT representative.
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 in service provision, including identification and resolution of problems with providers and services identified in the PCSP.
7. Provide supportive counseling to the participant and family, as appropriate.
8. Maintain records to provide supportive documentation of all conflict-free care 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 a participant's renewal or certification period, including ensuring the participant obtains an annual level of care redetermination.
10. Monitors implementation of PCSP via monthly (at minimum) contacts, which are documented in the applicable care management system, to ensure that participants are receiving services per their plan. For fee-for-service participants, the system of record is DC's electronic care management system; for D-SNP-enrolled participants, the D-SNP's care management system.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Health Risk Assessment and Mitigation Plan efforts are conducted on the initial visit to identify, analyze, and prioritize risks associated with the participant's conditions that will impact the provision of Medicaid or other services. The application of this Risk Assessment is incorporated in the clinical health assessment. A Risk Management Plan and a corresponding proposed action (mitigation) plan will be developed and implemented for identified risks. The PCSP will address any and all of the identified risks resulting from the comprehensive health clinical health assessment or any other assessment of the participant. Described in the PCSP will be what each service provider will do to try to avoid any negative outcomes from the identified risk factors.

Each waiver case management agency and D-SNP ICT shall ensure there are contingency plans (back-up plans) in case of emergency situations. There shall be a designated person to contact in case of emergency. All staff that provides direct care shall be well versed, and current in certification as applicable, in emergency techniques such as CPR and the participant's contingency/back-up plans. All contingency plans shall be documented in the PCSP and a copy of the plans should be in the participant's home in an identified location where it is readily accessible.

The contingency/back-up plans will be developed with the case manager or ICT, participant, and any person that the participant identifies need to have input in the decision making of the plan. Some types of contingency/back-up plans are: a designated person to be responsible for the care of the participant in case there is no PCA available to provide care for a specified shift in case of a call-in; a designated person to be responsible for the care of the participant every day when the PCA leaves if the participant receives 16 hours per day of care by a PCA; in case there is a weather emergency and no PCA can get to the participant's home to assist the participant; and ensuring the fire department knows whether individuals will need assistance evacuating in case of a fire (including by not limited to identification through Computer-Aided Dispatch).

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Case managers and ICTs will inform and remind waiver participants of the freedom of choice in the selection of all providers at all meetings or contacts as needed.

Potential participants are made aware of EPD Waiver providers and services through DHCF website and brochures, a public provider listing, the Aging and Disabilities Resource Center (ADRC), the DC Health Care Ombudsman and Long-Term Care Ombudsman's offices, during each visit from LTSS providers, as well as word of mouth. The case manager or ICT informs applicants and participants about all services at initial and subsequent meetings.

Appendix D: Participant-Centered Planning and Service Delivery

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

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

FOR PARTICIPANTS ENROLLED IN FEE-FOR-SERVICE MEDICAID

The District requires all PCSPs to be reviewed by the District's QIO to ensure compliance with PCSP and other waiver standards. That review process operates as follows:

1. After the participant has been determined eligible for waiver services, either initially or on an annual basis, the case manager submits the completed PCSP in the District's electronic case management system for review according to a pre-established list of review criteria (issued by DHCF) by the QIO.
2. If the QIO has questions about the PCSP or needs additional information, the QIO will request the information of the case manager via the electronic case management system.
3. If no additional information is needed or when all information is received and documented in the electronic case management system, then the QIO will provide approval of the PCSP for up to one (1) year and issue applicable service authorizations.

FOR PARTICIPANTS ENROLLED IN A CONTRACTED D-SNP

The District requires all PCSPs (including those incorporated into ICPs) containing EPD Waiver services to be subject to internal D-SNP organizational quality reviews, independent of the participant's ICT, conducted through policies and procedures subject to DHCF approval.

DHCF reviews annually a percentage of all fee-for-service waiver provider agencies' records and a sample of D-SNP PCSPs (including those incorporated into ICPs) for waiver participants.

1. DHCF reviews 10% of PCSPs created by each fee-for-service waiver case management agency and 5% of all D-SNP PCSPs containing waiver services among their enrolled participants. DHCF reviews for compliance with the EPD Waiver regulations, District and federal regulations, and the provider agency's or D-SNP's policies and procedures.
2. For enrolled fee-for-service waiver providers, deficiency statements are written with a request for an Opportunity for Improvement Plan (OFIP). The OFIP is reviewed and accepted or rejected as appropriate. For D-SNP ICTs, the D-SNP is subject to corrective action plans or other remediation as stipulated by the plan's contract with the District.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

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

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

Medicaid agency

Operating agency

Case manager

Other

Specify:

Service plans are maintained by the case management agencies or D-SNPs in the applicable electronic care management system. DHCF and the D-SNPs maintain copies of service plans in those systems consistent with timeframes prescribed by federal requirements.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

All case managers and ICTs should inform and remind the beneficiary of the freedom of choice in the selection of all providers at all meetings and contacts as needed.

DHCF is responsible for monitoring the implementation of the PCSP. The monitoring is completed at a minimum of annually. A review of the documentation in electronic records, complaint/incident documentation, and interviews are the methods used by DHCF to determine whether services are furnished in accordance with the service plans; participants have access to waiver services identified in the PCSP; services meet the needs of the beneficiaries; back-up plans are effective; participant health and welfare is assured; participants exercise freedom of choice of providers; and participants have access to non-waiver services if identified in the PCSP. Review of documentation and submission of requested reports is the method used to ensure follow-up to identified problems, whether among fee-for-service participants or D-SNP-enrolled participants. DHCF keeps documentation of all deficiency reports electronically.

Case management agencies (for fee-for-service participants) and Interdisciplinary Care Teams (ICTs) (for D-SNP participants) are responsible for ensuring that waiver participants have access to services and supports needed to live in the most integrated setting feasible, including EPD Waiver, non-waiver Medicaid, and other health care services. Case management agencies and ICTs are responsible for ensuring monthly monitoring to ensure the timely determination of level of care; PCSP development; services are delivered in the type/frequency as described in PCSP; and to ensure the beneficiary's health. Additionally, case management agencies and ICTs are responsible for ensuring that the PCSP, as applicable, is reviewed at least quarterly to review and update risk factors, goals, outcomes, services, review service utilization, and to resolve issues.

The case management agency or contracted D-SNP is responsible for monitoring the staff and contractors to ensure implementation of the PCSP and the health and welfare of the participant. DHCF is responsible for monitoring the case management agencies and D-SNPs to ensure PCSPs are implemented and supporting the health and welfare of the participants.

DHCF monitors the case management agencies and D-SNPs annually, at minimum.

MONITORING AND FOLLOW-UP METHODS

For case management agencies, DHCF makes unannounced monitoring visits to each provider agency. DHCF conducts an entrance conference to explain the purpose of the visit and inform the agency of the documentation that will be needed to complete the annual monitoring visit. DHCF requests a copy of all current EPD waiver participants to randomly select a sampled percentage of the participants' clinical records to review. DHCF will request to review records of participants that had voiced complaints about the provider agencies and conducts interviews of the staff, as appropriate. DHCF reviews personnel files, complaint/incident records, and policies/procedure manuals. After review of clinical records is completed DHCF conducts a limited number of home visits to participants in the provider's care.

DHCF will complete a standardized monitoring tool, which may require an Opportunity for Improvement Plan (OFIP) as appropriate. The completed tool will be sent to the provider agency for review and action within fifteen (15) days, by which date the agency must return the OFIP. DHCF will provide the agency with an acceptance letter of approval of the OFIP. If the OFIP is not acceptable (i.e.: lack of documentation describing how the deficiency will be corrected and plans to alleviate recurrence of the identified deficient area), DHCF will follow its alternative sanctions process.

For contracted D-SNPs, DHCF similarly conducts annual monitoring or contractual audit activities. While the scope of the D-SNP's annual audit will be broader than EPD Waiver compliance alone, DHCF uses this process to provide oversight of PCSP development and implementation, and overall performance monitoring of the D-SNPs' comprehensive, integrated care management activities. DHCF conducts an entrance conference to explain the purpose of the visit and inform the health plan of the documentation that will be needed to complete the annual oversight. DHCF requests a listing of all current EPD waiver participants to randomly select a sampled percentage of the participants' clinical records to review. DHCF will request to review records of participants that had voiced complaints about the health plans or conduct interviews of the staff, as appropriate. DHCF reviews care management records, personnel files, and appeal and grievance records. After review of the clinical records is completed, DHCF may conduct a limited number of home visits to participants in the provider's care.

DHCF will complete a standardized audit tool for each year's monitoring activities, which may require a corrective action plan if warranted. The corrective action plan process will proceed according to the standards set forth in the D-SNP's contract with the District.

b. Monitoring Safeguards. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. Sub-assurance: *Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

Performance Measures

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

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

Performance Measure:

(9) D.a.1 Percentage of waiver participants who have a person-centered service plan (PCSP) that addresses personal goals. Numerator= Number of waiver participants with a PCSP that addresses personal goals. Denominator= Number of waiver participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid	Weekly	100% Review

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px;"> Confidence Level 95 / Error rate 10 Confidence Level 90 / Error rate 10 Confidence Level 90 / Error rate 15 Confidence Level 90 / Error rate 20 </div>
Other Specify: <div style="border: 1px solid black; padding: 2px;">Contracted D-SNPs</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

(10) D.a..1 Percentage of waiver participants with a PCSP that addresses all assessed needs, including health and safety risks. Numerator= Number of waiver participants with a PCSP that addresses all assessed needs, including health and safety risks. Denominator= Number of waiver participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		Confidence Level 95 / Error rate 10 Confidence Level 90 / Error rate 10 Confidence Level 90 / Error rate 15 Confidence Level 90 / Error rate 20
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<div style="border: 1px solid black; width: 100%; height: 20px;"></div>

b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures

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

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

c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.

Performance Measures

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

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

Performance Measure:

(12) D.c..2 Percentage of PCSPs updated at least annually. Numerator= Number of PCSPs updated at least annually. Denominator= Number of PCSPs due to be updated.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input type="text"/>

Performance Measure:

(11) D.c..1 Percentage of waiver participants whose PCSP was revised as needed to address changing needs. Numerator= Number of waiver participants whose PCSP was revised to address a change in needs. Denominator= Number of waiver participants with a change in needs.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

Performance Measures

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

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

Performance Measure:

(13)D.d.1 Percentage of waiver participants who received services specified in the PCSP in accordance with the type,scope,amount,frequency,and duration specified in the PCSP. Numerator= Number of waiver participants who received services specified in the PCSP in accordance with the type, scope,amount,frequency, and duration specified in the PCSP.Denominator= Number of waiver participants reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px;"> Confidence Level 95 / Error rate 10 Confidence Level 90 / Error rate 10 Confidence Level 90 / Error rate 15 Confidence Level 90 / Error rate 20 </div>
Other Specify: <div style="border: 1px solid black; padding: 2px;">Contracted D-SNPs</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Sub-State Entity	Quarterly
Other Specify: Contracted D-SNPs	Annually
	Continuously and Ongoing
	Other Specify:

e. *Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.*

Performance Measures

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

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

Performance Measure:

(14)D.e.1 Percent of new waiver participants whose records have a signed freedom of choice form. Numerator = Number of new waiver participants whose records have a signed freedom of choice form. Denominator = New waiver participants.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		Interval = <input type="text"/>
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

(15)D.e.2 Percentage of waiver participants with signed PCSP documentation of

agreements indicating choice of providers and services. Numerator= Number of waiver participants with signed PCSP documentation of agreements indicating choice of providers and services. Denominator= Total number of waiver participants.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="408 517 799 562" type="text" value="Contracted D-SNPs"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="871 757 1262 835" type="text"/>

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

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

On a monthly basis DHCF convenes a multi-division Quality Management Committee (QMC). The purpose of QMC is to provide oversight of the waiver program to evaluate the program's performance and implement quality improvement strategies for continuous quality improvement.

Performance measures are derived from the actual EPD waiver measures approved by CMS or other ad hoc measures that the program feels are important to monitor. A slate of measures is maintained, reported, tracked, and trended.

The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF.

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

The DQHO partners with LTCA conduct comprehensive review for assessing the overall performance of the EPD Waiver. It includes an iterative process for assessing performance, identify opportunities for improvement and outline recommendations for targeted quality improvement processes and measuring and monitoring the program's overall effectiveness. Additionally, all applicable providers shall be subject to quality standards , including but not limited to, guidance issued by the Centers for Medicare and Medicaid Services (CMS) and rules issued by DHCF's quality improvement activities.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

(1) DHCF meets with providers and D-SNPs (individually or as a group) to deliver education regarding detected problems. This will most often be used for a first-time occurrence of a problem of a specific type. If a problem is detected across multiple providers, DHCF will send an official written notification to all providers and D-SNPs describing the problem, and how DHCF requires it to be addressed. Documentation of these efforts will be made by DHCF as notes on individual providers or D-SNPs, notes on the agenda of monthly provider meeting, or as notes of copies of the transmittals.

(2) Problems that recur will be addressed through additional training, and the delivery of a written notice from DHCF requiring the correction of the problem. DHCF is also responsible for written communication with individual providers or D-SNPs, and will retain documentation of such communications.

(3) Problems that persist will be addressed through more stringent means, including alternative sanctions imposed on Medicaid-enrolled providers, corrective action plans required of the contracted D-SNPs, or the recoupment of Medicaid payments associated the problem. Such recoupments are handled by DHCF's program integrity and health care operations teams, which maintain documentation of all such recoupments.

(4) Serious and/or repeated violations of standards for service planning can result in termination of the provider or D-SNP in accordance with DHCF's regulations. DHCF maintains documentation of all such provider or contractor actions.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="320 1424 794 1469" type="text" value="Contracted D-SNPs"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="866 1693 1340 1771" type="text"/>

c. Timelines

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

No

Yes

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

DHCF and/or its designee(s) are responsible for reviewing PCSPs to ensure that the document contains all the required information prior to the approval of services. Incomplete PCSPs are not approved. Additionally, DHCF's oversight and monitoring approach selects random PCSPs to verify whether the service plans were developed in accordance with DHCF guidelines.

All reviewed PCSPs must demonstrate that all services are provided in type, scope, amount, duration, and frequency in accordance with the service plan. Otherwise, the PCSP is determined non-compliant. For enrolled fee-for-service providers, a discovery is generated detailing the deficiency for remediation. For contracted D-SNPs, remedial action is taken consistent with the audit protocols described in the D-SNP's contract with the District.

As mentioned under question a.ii. (Methods for Discovery), DHCF has in place several mechanisms to monitor and analyze EPD waiver performance. The LTCA Oversight and Monitoring Division conducts compliance reviews on performance measures of all waiver assurances. The LTCA Oversight and Monitoring Division is responsible for the discovery and remediation process of individual and systemic issues.

DHCF additionally has a Program Analyst dedicated to the long-term services and supports programs, including the EPD waiver. This Program Analyst has assisted in development and implementation of a work plan to ensure that all elements of the waiver are in compliance. The Analyst also chairs the Quality Management Committee meeting on a monthly basis that implements the Quality Strategy outline in Appendix H including a Continuous Quality Improvement plan. This process includes the development of Quality Improvement Projects for any assurance that is performing below 86%.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

OPPORTUNITIES FOR PARTICIPANT DIRECTION:

All waiver participants have the opportunity to exercise employer authority to recruit, hire, supervise, and discharge qualified participant-directed workers (PDWs) who provide participant-directed community support (PDCS). For all waiver participants--both Medicaid fee-for-service participants and D-SNP-enrolled participants--Financial Management Services (FMS) and Support Broker services are provided as administrative activities by a Vendor Fiscal/Employer Agent (VF/EA) FMS-Support Broker entity. For Medicaid fee-for-service waiver participants, the VF/EA FMS-Support Broker entity is selected through a competitive procurement process.

Waiver participants who choose to enroll in the Services My Way program and self-direct their PDCS have access to all other EPD Waiver services except provider-managed Personal Care Aide (PCA) services. Provider-managed PCA services are considered duplicative of the PDCS services available under the Services My Way program, with the only difference being the service delivery method. Thus, waiver participants may elect to receive either traditional HCBS or participant-directed HCBS or a combination of both. Duplication of services will not occur.

HOW PARTICIPANTS ACCESS PARTICIPANT-DIRECTED SERVICES:

Both current and new waiver participants (both fee-for-service and D-SNP enrollees) have the opportunity to elect to enroll in the Services My Way program and self-direct an approved PDCS.

Current Waiver Participants –

For current waiver participants, the assigned waiver case manager or D-SNP ICT informs the waiver participant about the program and the opportunity to self-direct approved PDCS using standard, easy-to-understand information approved by DHCF. For waiver participants not enrolled in the Services My Way program, this information is provided at each reassessment for services, any time the participant's PCSP is updated, and upon request by the participant. All current waiver participants living in their own private residence, or in the home of a family member or friend, have the option to enroll in the Services My Way program and develop a new PCSP and PDS budget that includes PDCS. The waiver case manager or D-SNP ICT will discuss the traditional and participant-directed service delivery options to ensure each waiver participant understands the different opportunities available, his/her roles and responsibilities, and options for receiving supports.

If a waiver participant wishes to enroll in the Services My Way program, the waiver case manager or D-SNP ICT reviews the requirements of the program with the participant and develops, with the participant, a revised PCSP that includes the participant-directed service option. For fee-for-service participants, the case manager sends the revised PCSP to DHCF and the VF/EA FMS support broker entity, which then assigns a support broker and initiates Services My Way enrollment. For D-SNP-enrolled participants, the revised PCSP proceeds through the D-SNP's internally established process (subject to DHCF review and approval) to approve the PCSP, assign a support broker, and initiate Services My Way enrollment.

The assigned support broker conducts a comprehensive orientation and training with the waiver participant and the participant's authorized representative, if applicable, using standard, easy-to-understand materials approved by DHCF. The support broker also assists the participant and authorized representative, if applicable, in completing forms and agreements and providing required information as requested in the Participant/Representative Employer Enrollment Packet and PDW Employment prepared and distributed by the VF/EA FMS-Support Broker entity or D-SNP, as well as any other forms and/or agreements required by DHCF.

For fee-for-service participants, once training and all required documentation has been completed, the VF/EA FMS-Support Broker entity submits the participant's PDS budget--developed by the participant, the authorized representative, if applicable, and the support broker--to DHCF for review. Upon approval of the PDS budget, DHCF issues the appropriate service authorizations and submits the necessary information to the VF/EA FMS-Support Broker entity for enrollment of the participant and the participant's PDW(s) into its system.

For D-SNP-enrolled participants, once training and all required documentation has been completed, the participant's PDS budget--developed by the participant, the authorized representative, if applicable, and the support broker--is subjected to the D-SNP's internal utilization management and care management processes for review. Upon approval of the PDS budget, the D-SNP issues the appropriate service authorizations and coordinates the enrollment of the participant and the participant's PDW(s) into its or its agent's system.

New Fee-for-Service Waiver Participants –

New waiver participants are connected with waiver services through the Aging and Disability Resource Center (ADRC) within the DC Office on Aging (DCOA). Medicaid Enrollment Specialists at the ADRC provide comprehensive options counseling and introduce EPD Waiver applicants to the Services My Way program and participant-directed services using standard, easily understandable information approved by DHCF. If an EPD Waiver applicant expresses an interest in enrolling in the Services My Way program, once the applicant is enrolled in the EPD Waiver and a case manager is assigned, the newly enrolled participant will work with the waiver case manager and assigned support broker as described above for currently enrolled waiver participants.

New D-SNP Waiver Participants –

D-SNP enrollees seeking any EPD Waiver services, including enrollment in Services My Way, are provided information and options counseling by their ICT as a part of routine care management activities. The ICT introduces the Services My Way program and participant-directed services using standard, easily understandable information approved by DHCF. If a D-SNP enrollee expresses an interest in enrolling in the Services My Way program, the D-SNP facilitates his/her enrollment into the EPD Waiver via the LOC assessment and the Medicaid long-term care application process. Once the applicant is enrolled in the EPD Waiver, the newly enrolled waiver participant will work with the D-SNP ICT and assigned support broker as described above for currently enrolled waiver participants.

ENTITIES SUPPORTING INDIVIDUALS:

For fee-for-services waiver participants in Services My Way, the VF/EA FMS-Support Broker entity selected through a competitive procurement process provides support and facilitates participants' success in self-directing their approved PDCS and managing their PDS budgets. The VF/EA FMS-Support Broker entity operates in accordance with 26 U.S.C. § 3504 and Rev. Proc. 70-6, as modified by REG-137036-08 and Rev. Proc. 2013-39, and provides both financial management services (FMS) and information and assistance (I&A) services as administrative activities. The scope of FMS and I&A services provided by the VF/EA FMS-Support Broker entity are described in detail in subsequent sections.

For D-SNP-enrolled waiver participants in Services My Way, the D-SNP is ultimately accountable for all care management and supports, though it may delegate all or a portion of VF/EA FMS and Support Broker functions to its subcontractors. The D-SNP must operate Services My Way services in accordance with 26 U.S.C. § 3504 and Rev. Proc. 70-6, as modified by REG-137036-08 and Rev. Proc. 2013-39, and is subject to DHCF oversight and monitoring activities.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.

Select one:

Participant: Employer Authority. As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

Participant: Budget Authority. As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

Both Authorities. The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

Waiver is designed to support only individuals who want to direct their services.

The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

All waiver participants receive information about using participant-directed services (PDS) and enrolling the Services My Way program. Information regarding PDS is initially provided to new waiver participants by Medicaid Enrollment Specialists at the ADRC or their D-SNP, and to current waiver participants by their waiver case manager or D-SNP ICT. For all waiver participants, the case manager or D-SNP ICT documents the participant's choice of service delivery model in the PCSP. Case managers or D-SNP ICTs also advise participants of the opportunity to change their method of waiver service delivery at any time. Case managers and D-SNP ICTs also re-introduce and provide information about PDS to waiver participants each time the participant is reassessed for services and each time the participant's PCSP is updated if the waiver participant is not already enrolled in the Services My Way program, as well as upon the participant's request.

To ensure that a new waiver participant has received all information necessary to discuss the Services My Way program with the case manager or D-SNP ICT at the initial meeting to develop the PCSP and is able to make an informed decision regarding participation in the program, information regarding PDS is provided to new waiver participants promptly upon enrollment in the waiver. Information regarding PDS is provided to current waiver participants at each reassessment and each time the PCSP is updated, as well as upon the participant's request. Waiver participants may request information regarding PDS at any time and may elect to enroll in the Services My Way program at any time, affording participants sufficient time to make an informed decision regarding participation in the program.

Orientation and training materials provided to participants, and their authorized representatives, as appropriate, include, but are not limited to: details about self-directing their PDS, managing their PDS budget, using FMS and support broker services, being a common law employer, and general Medicaid and non-Medicaid rights and responsibilities. Orientation and training materials specifically include information regarding the potential liabilities associated with being a common law employer of the participant's PDW(s) and with managing the participant's PDS budget.

DHCF has distributed informational materials to the Medicaid Enrollment Specialists at the ADRC and to all waiver case managers as part of their PDS training. DHCF shares informational materials with the D-SNPs, which in turn provide materials and training to D-SNP care management staff. Materials are also available on the DHCF website. The materials are written to comply with all relevant federal and District standards regarding language access.

Support brokers are responsible for providing orientation and training to the participant/representative employer prior to employment of a PDW. Initial orientation and training is based upon a standard curriculum developed by DHCF and includes the following:

- Review of the information and forms contained in both the Participant/Representative Employer Enrollment and PDW Employment and Individual-Directed Goods and Services Engagement Packets and directions for how they should be completed;
- The role and responsibilities of the common law employer;
- The role and responsibilities of the VF/EA FMS Division and support broker;
- The process for receipt and processing of PDW timesheets and payroll checks;
- The process for purchasing approved individual-directed goods and services from vendors, including submitting invoices for payment;
- Effective practices for recruiting, hiring, training, supervising, managing, and firing PDWs;
- The process for resolving issues and complaints; and
- Reviewing workplace safety issues, obtaining workers' compensation insurance coverage and reporting PDW workplace injuries.

In addition, the support broker is responsible for providing ongoing skills training to participants and working with the participant's case manager or D-SNP ICT and VF/EA FMS Division to identify any participants who may need and/or desire additional employer skills training.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: *(check each that applies)*:

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The participant may designate an authorized representative to exercise employer-related responsibilities. An authorized representative is a person who is the participant's substitute decision-maker, family member, or any other identified individual who willingly accepts responsibility for performing employer and budget management tasks that a participant is unable to perform him or herself, and includes serving as the common law employer of the participant's PDW(s).

An authorized representative must evince a personal commitment to the participant, be willing to follow the participant's wishes and respect the participant's preferences, while using sound judgment to act in the best interest of the participant. The authorized representative must be actively engaged in the participant's life and live in his or her community. An authorized representative also must execute a Designation of Authorized Representative form.

A participant may only designate one (1) authorized representative at a time. A participant may revoke an authorized representative designation at any time by notifying the support broker, who will assist the participant with completion of the required form. A participant may have one (1) of three (3) types of authorized representative. These include:

- (1) Pre-Determined Representative – A legal guardian or other court-appointed representative in place at the time of the participant's enrollment in the Services My Way program.
- (2) Voluntary Representative – An individual twenty-one (21) years of age or older who is actively engaged in the participant's life and lives in the participant's community.
- (3) Mandated Representative – An individual who meets the criteria of a voluntary representative who is designated by the participant if DHCF or its agent determines that the participant requires an authorized representative in order to continue participation in the Services My Way program.

DHCF or a contracted D-SNP may determine that a participant requires an authorized representative to continue participation in the Services My Way program if the participant has demonstrated an inability to self-direct his/her services after additional counseling, information, remedial training and/or assistance has been offered by the participant's support broker. If DHCF or the D-SNP determines that a participant requires an authorized representative to continue participation in the Services My Way program, DHCF or the D-SNP must issue a written notice to the participant, support broker, and waiver case manager, which:

- (1) Informs the participant that designation of an authorized representative is required in order to continue participating in the Services My Way program;
- (2) Details the reason(s) that designation of an authorized representative is required;
- (3) Provides instructions on designating an authorized representative; and
- (4) Provides information on the participant's right to appeal the determination and specific information about how to initiate the appeal process.

No authorized representative may receive any monetary compensation for serving as a participant's authorized representative for the Services My Way program. An authorized representative may only serve one (1) Services My Way participant and may not serve as a paid PDW for the participant. All authorized representatives must adhere to the following requirements:

- (1) Effectuate, as much as possible, the decision the waiver participant would make for him/herself;
- (2) Accommodate the participant, to the extent necessary, so he/she can participate as fully as possible in all decisions; and
- (3) Give due consideration to all information including the recommendations of other interested and involved parties.

Waiver participants and authorized representatives are responsible for working collaboratively to ensure that:

- (1) Waiver participants receive needed PDCS from qualified PDWs; and
- (2) PDCS services and individual-directed goods and services are provided in accordance with the participant's PCSP and PDS budget.

The following safeguards are in place to ensure that an authorized representative functions in the best interests of the participant:

- Authorized representatives are required to complete and sign an Authorized Representative Designation Form, which includes attestations that the authorized representative will make decisions in the participant's best

interest, has not been convicted of a felony, and will attend initial orientation and ongoing training as required by DHCF.

- The performance of an authorized representative will be continually monitored by the participant’s support broker and waiver case manager or D-SNP ICT, either of whom may alert DHCF or the D-SNP if there is a concern as to whether the authorized representative is acting in the participant’s best interest.
- PDWs may also alert the participant’s support broker or waiver case manager or D-SNP ICT with any concerns regarding an authorized representative’s performance.

Appendix E: Participant Direction of Services

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g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Individual Directed Goods and Services		
Participant-Directed Community Support Services		
Personal Care Aide		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

Yes. Financial Management Services are furnished through a third party entity. (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

FMS are provided to fee-for-service waiver participants enrolled in the Services My Way program by a District-wide, qualified VF/EA FMS-Support Broker entity, selected through a competitive procurement process (RFP). FMS for D-SNP waiver participants enrolled in the Services My Way program are rendered through a sub-contractual arrangement between the D-SNP and an FMS entity that is monitored by the D-SNP and DHCF.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

For D-SNP waiver participants enrolled in Services My Way, payment for FMS is included in the District’s capitation payments to the contracted D-SNPs.

For fee-for-service waiver participants enrolled in Services My Way, the VF/EA FMS-Support Broker entity receives a per participant per month administrative fee for the financial management services provided through contract. The selected vendor must apply the per participant per month fee consistently for each participant actively enrolled with the vendor.

The VF/EA FMS-Support Broker entity receives a separate per participant per month administrative fee for the support broker service provided by the VF/EA FMS-Support Broker entity, established through the competitive procurement process. The selected vendor must apply the per participant per month fee consistently for each participant actively enrolled with the vendor.

The VF/EA FMS-Support Broker entity receives a separate one-time set-up fee for enrolling the participant/representative employer with the VF/EA FMS-Support Broker entity. The one-time set-up fee is consistent for each participant/representative employer. The VF/EA FMS- Support Broker entity receives a one-time expedited enrollment fee for enrolling the participant/representative employer with the VF/EA FMS-Support Broker entity within ninety (90) days of receiving the referral for enrollment.

The VF/EA FMS-Support Broker entity receives a separate one-time set-up fee for enrolling a qualified PDW in its PDW payroll system. The one-time set-up fee is consistent for each PDW.

The VF/EA FMS-Support Broker entity receives a fee for producing the Services My Way guidebook.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- Assist participant in verifying support worker citizenship status**
 - Collect and process timesheets of support workers**
 - Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
 - Other**
- Specify:*

Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant's participant-directed budget**
- Track and report participant funds, disbursements and the balance of participant funds**
- Process and pay invoices for goods and services approved in the service plan**
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- Other services and supports**

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

The VF/EA FMS/Support Broker entity operates in accordance with 26 U.S.C. §3504 and Rev. Proc. 70-6, as modified by REG-137036-08 and Rev. Proc. 2013-39, as well as applicable federal and District labor, citizenship and immigration, and workers' compensation requirements. The entity offers the following FMS:

- Obtaining federal and District approval to perform as a VF/EA (e.g., filing and submission of IRS Forms 2678 and 8821, and DC powers of attorney for income tax and unemployment tax filing and payments);
- Preparing and maintaining a DC-specific VF/EA FMS-Support Broker Policies and Procedures Manual that includes written policies, procedures and internal controls for all VF/EA FMS and Support Broker tasks and updating it as needed and at least annually;
- Staying up-to-date with all federal and state program, labor, employment tax and workers' compensation insurance requirements related to participant/representative employers, their PDWs, and VF/EA FMS;
- Developing a transition plan for when/if the VF/EA FMS – Support Broker entity changes to facilitate the transition process and in accordance with DHCF and/or D-SNP requirements;
- Receiving and disbursing Medicaid funds and monitoring any balances;
- Submitting claims for Medicaid reimbursement for PDCS and individual-directed goods and services rendered;
- Submitting invoices to DHCF or the D-SNP for VF/EA FMS and Support Broker administrative fees;
- Providing customer service (i.e., toll free phone and TTY numbers and informational materials that comply with all federal and District standards regarding disability and language access) per DHCF requirements;
- Preparing and distributing Participant/Representative-Employer Enrollment Packets;
- Collecting and processing the completed forms, agreements and information requested in the Participant/Representative-Employer Enrollment Packets;
- Preparing and distributing the PDW Employment and Individual-Directed Goods and Services Vendor Engagement Packets;
- Collecting and processing the completed forms, agreements and information requested in the PDW Employment and Individual-directed Goods and Services Vendor Engagement Packets;
- Enrolling participant/representative employers with the VF/EA FMS-Support Broker entity;
- Enrolling PDWs in the VF/EA FMS-Support Broker entity's payroll system;
- Verifying that criminal background checks are conducted on all prospective PDWs;
- Reporting PDWs in the DC New Hire Reporting System;
- Assisting participant/representative employers with determining citizenship and legal alien status by processing the US CIS Form I-9;
- Collecting and processing PDWs' timesheets in accordance with a participant's PCSP and PDS budget;
- Processing PDW payroll including paying wages in compliance with the DC Living Wage Act and filing and paying federal and District of Columbia required taxes;
- Processing garnishments, liens, and levies against PDWs' wages;
- Processing end-of-year federal and state tax activities including IRS Forms W-2, FICA refunds, and DC tax reconciliations, as required;
- Receiving and processing invoices from individual-directed goods and services vendors for payment;
- Processing returned payments (i.e. payroll checks or payments to individual-directed goods and services providers) in accordance with the District's Unclaimed Property Law;
- Managing the receipt and renewal of workers' compensation insurance policies for waiver participant/representative-employers;
- Establishing and maintaining current and archived records and files in a confidential and secure manner and for required time period;
- Implementing and testing a disaster recovery plan for electronic data and files;
- Preparing and submitting DHCF and/or D-SNP required reports; and

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

DHCF monitors and assesses the readiness and ongoing performance of its contracted VF/EA FMS-Support Broker entity through a number of monitoring activities. DHCF conducted an on-site readiness review of the VF/EA FMS-Support Broker entity prior to the contract award. DHCF also conducts an annual VF/EA FMS-Support Broker Entity Quality Assessment and Performance Review using the methods described in Appendix A (5) and (6). The VF/EA FMS-Support Broker entity is required to prepare and submit monthly utilization and expenditure reports to DHCF; the D-SNPs' ongoing monthly, quarterly, and annual reporting will be used to assess the performance of the FMS entities subcontracted by the D-SNPs. DHCF's Office of Contracts and Procurement (OCP) and the QMC will address other quality assurance related issues as they arise.

The VF/EA FMS-Support Broker entity is required to conduct an annual participant/representative employer satisfaction review and provide the results to DHCF.

Furthermore, the integrity of financial transactions performed by the FMS is ensured through inclusion of Services My Way participants in the quarterly compliance reviews conducted by DHCF, as discussed in Appendix I.

Appendix E: Participant Direction of Services

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j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case and care management services facilitate coordination of all Medicaid and waiver services, including participant-directed services, provided to participants so that services are delivered in a well-coordinated, safe, timely and cost-efficient manner that addresses the participant's specific needs. Waiver case management services for all waiver participants, including both fee-for-service participants and participants concurrently enrolled in a D-SNP, are detailed in Appendix D. In addition to all responsibilities detailed in Appendix D, a participant's waiver case manager or D-SNP ICT performs the following information and assistance tasks related to PDS:

- Conducts initial outreach and education on the Services My Way program for waiver participants using standard outreach and PDS information materials, and documents the participant's decision on whether or not to use PDS.
- Re-introduces the Services My Way program to waiver participants not enrolled in PDS each time the participant's PCSP is updated, each time the participant is reassessed, and upon the participant's request.
- Identifies waiver participants' desired outcomes for using PDS under a person-centered planning process and includes PDS in the participant's PCSP.
- Provides copies of the participant's updated and approved PCSP to the participant and authorized representative, as appropriate, the waiver participant's support broker, and DHCF.
- Monitors participant/representative employer performance in using PDS in collaboration with the participant's support broker.
- Participates in the Remediation, Training, and Termination process with DHCF, VF/EA FMS Division, support broker, D-SNP, and other entities, as appropriate.
- Assesses participants' and representatives', as appropriate, receipt of and satisfaction with PDS in collaboration with the participant's support broker.

Waiver Service Coverage.

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Individual Directed Goods and Services	
Case Management	
Adult Day Health	
Chore Aide	
DSNP/Managed Care Capitated Waiver Services	
Assisted Living	
Community Transition Services	
Participant-Directed Community Support Services	
Homemaker	
Personal Care Aide	
Respite	
Environment Accessibility and Adaptation Services	

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

For fee-for-service participants enrolled in Services My Way, the Support Broker Division of the VF/EA FMS-Support Broker entity furnishes information and assistance (I&A) supports to participants and their representatives, as appropriate. As detailed above, the VF/EA FMS-Support Broker entity will receive a standard per-participant per-month fee for support broker services.

For D-SNP participants enrolled in Services My Way, the D-SNP is responsible for the delivery and oversight of support broker services, whether it provides such services directly or through a delegated entity. In either case, the support broker entity furnishes information and assistance (I&A) supports to participants and their representatives, as appropriate.

A support broker furnishes the following I&A supports related to PDCS and individual-directed goods and services:

- Provides initial orientation and skills training to participants and authorized representatives, as appropriate, on using the Services My Way program, self-directing their PDS and managing their PDS budget, using FMS and support broker services, being a common law employer, and general Medicaid and non-Medicaid rights and responsibilities.
- Provides ongoing skills training to participants and authorized representatives, as appropriate, on using the Services My Way program, self-directing their PDS and managing their PDS budget, using FMS and support broker services, being a common law employer, and general Medicaid and non-Medicaid rights and responsibilities as needed.
- Assists participant/representative employers in completing the forms and agreements included in the Participant/Representative-Employer Enrollment Packet and Participant-directed Worker (PDW) Employment and Individual-Directed Goods and Services Vendor Engagement Packet.
- Assists participant/representative employers in developing, implementing, monitoring effectiveness and revising, as needed, emergency back-up and natural support plans and designated emergency back-up staff and natural supports.
- Assists waiver participants in designating an authorized representative, as necessary, assessing effectiveness of the authorized representative and selecting a new authorized representative if needed.
- Develops, with the participant and authorized representative, as appropriate, the participant's PDS budget for approval by DHCF or the D-SNP, as applicable.
- Updates, with the participant and authorized representative, as appropriate, the participant's PDS budget and submits the revised budget for approval by DHCF or the D-SNP, as applicable.
- Develops with the participant and his/her representative, as appropriate, proposals to reallocate PDS budget funds from labor to individual-directed goods and services or vice versa and submits them for approval by DHCF or the D-SNP, as applicable.
- Assists the participant and authorized representative, as appropriate, in tracking PDS expenditures in accordance with the participant's PDS budget.
- Assists participants and authorized representatives, as appropriate, in making decisions about purchasing individual-directed goods and services.
- Assists participants and authorized representatives, as appropriate, in resolving issues as they arise.
- Conducts periodic in-home visits and phone calls with participants to monitor that their PDS is being provided in accordance with the participant's PCSP and PDS budget, their health and safety and to answer questions or concerns.
- Assesses effectiveness of participant's authorized representative and suggests modification, as needed.
- Assesses effectiveness of participant/representative employer's emergency PDW backup plan and designated staff and suggests modifications, as needed.
- Assesses effectiveness of participant/representative employer's natural supports plan and delegated natural supports and suggests modifications, as needed.
- Reports critical incidents as a mandatory reporter.
- Participates in Remediation, Training, and Termination processes with DHCF or the D-SNP, as applicable, waiver case manager or D-SNP ICT, VF/EA FMS Division, and other entities, as applicable and appropriate.

As noted above, DHCF conducts annual quality assessment and performance activities with contracted entities. This includes an annual VF/EA FMS-Support Broker Entity Quality Assessment and Performance Review for the entity providing these services for fee-for-service waiver participants. All quality assessments and performance reviews of the VF/EA FMS-Support Broker entity include review of the I&A services described above.

Appendix E: Participant Direction of Services

k. Independent Advocacy (*select one*).

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

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I. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Waiver participants have the option to transition from participant direction to a provider-managed service delivery model at any time.

For D-SNP participants, this process is managed by the participant's D-SNP ICT and accompanied by corresponding changes to the participant's PSCP, coordination with providers and other entities, and requisite support of the participant and/or representative through the administrative process to ensure continuity of services.

For fee-for-service participants, this process is initiated by the participant completing the Voluntary Participant Termination Notice and submitting to DHCF. Upon receipt of the notice, DHCF informs the participant's support broker and waiver case manager of the participant's decision. The waiver case manager then guides the waiver participant through the transition process and is responsible for transitioning the participant to the traditional model of service. The waiver case manager ensures there is no break in service during the transition period and coordinates the approval by DHCF, or its designee, of the request to initiate agency-based personal care aide services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Remediation, Training, and Termination Protocol -

DHCF has developed a remediation, training, and termination protocol for participant/representative-employers who fail to comply with the terms of the Services My Way Participant/Representative-Employer Agreement. Non-compliance with the Participant/Representative-Employer Agreement may be identified by the VF/EA FMS-Support Broker entity, the participant's support broker, the waiver case manager or D-SNP ICT, or DHCF staff. Non-compliance with one or more terms of the Participant/Representative-Employer Agreement identified at a given point in time constitutes an "episode of non-compliance" for the purposes of the Remediation, Training, and Termination Protocol.

Participant/representative-employers are allowed two (2) episodes of non-compliance with any employer-related responsibility delineated in the Participant/Representative Employer Agreement during the first twelve (12) month period of enrollment in the Services My Way program. This allows new program participants to become familiar with all employer-related responsibilities and provides an opportunity for additional training and support where required as participants adjust to the program terms. Thereafter, participant/representative-employers are allowed an additional two (2) episodes of non-compliance with any employer-related responsibility delineated in the Participant/Representative-Employer Agreement during each thirty-six (36) month period after the initial twelve (12) month period of enrollment in the Services My Way program. The third episode of non-compliance occurring within any thirty-six (36) month period of enrollment will result in the participant's involuntary termination from the Services My Way program and transition to agency-based personal care aide services.

First Episode of Non-Compliance -

When a participant/representative-employer is found to be out of compliance with the Participant/Representative Employer Agreement for the first time within the first twelve (12) month period of enrollment and every thirty-six (36) month period thereafter, the following steps occur:

- A. DHCF or the D-SNP issues a notice of non-compliance to the participant/representative-employer, the support broker, and the waiver case manager or D-SNP ICT, which:
 - i. Identifies the issue(s) of non-compliance and requests that the issue(s) be corrected (if possible), and not repeated;
 - ii. Details requirements of the Corrective Action Plan (CAP) the participant will create to address the issue(s);
 - iii. Offers training and/or technical assistance;
 - iv. Encourages the participant/representative employer to direct questions to the support broker, including requesting training, obtaining assistance in preparing the CAP, and designating an authorized representative;
 - v. Identifies consequences of further non-compliance with the Participant/Representative Employer Agreement; and
 - vi. Provides details on the participant's appeal rights for termination from the program, should three (3) episodes of non-compliance occur.
- B. Within five (5) business days of issuing the notice of non-compliance, the support broker contacts the participant/representative-employer to discuss the episode of non-compliance.
- C. Within five (5) business days of the above-mentioned contact, the participant, with the assistance of the authorized representative and/or the support broker, if needed, draft and sign a written CAP regarding the episode of non-compliance.
 - i. The support broker provides copies of the signed CAP to the waiver case manager or D-SNP ICT and the applicable VF/EA FMS-Support Broker entity.
 - ii. The support broker is responsible for monitoring the CAP. If the participant or authorized representative, as applicable, fails to implement all or a portion of the CAP, this is considered an episode of non-compliance and is reported to the Services My Way Program Coordinator.

Second Episode of Non-Compliance -

When a participant/representative-employer is found to be out of compliance with the Participant/Representative Employer Agreement for a second time within the first twelve (12) month period of enrollment and every thirty-six (36) month period thereafter, the following steps occur:

- A. DHCF or the D-SNP issues a second notice of non-compliance to the participant/representative-employer, the support broker, and the waiver case manager or D-SNP ICT, which contains all the information detailed above for the initial notice of non-compliance.
- B. Within five (5) business days of issuing the second notice of non-compliance, the support broker contacts the participant/representative-employer to discuss the episode of non-compliance.

C. Within five (5) business days of the above-mentioned contact, the participant, with the assistance of the authorized representative and/or the support broker, if needed, draft and sign a written CAP regarding the episode of non-compliance. As detailed above, the support broker is responsible for monitoring the CAP, and failure to implement all or a portion of the CAP is considered an episode of non-compliance.

Third Episode of Non-Compliance -

When a participant/representative-employer is found to be out of compliance with the Participant/Representative-Employer Agreement for a third time within the first twelve (12) month period of enrollment and every thirty-six (36) month period thereafter, the following steps occur:

A. DHCF or the D-SNP issues a PDS termination notice to the participant/representative-employer, the support broker, and the waiver case manager or D-SNP ICT, which:

- i. Identifies the three (3) episodes of non-compliance;
- ii. Clearly states that DHCF or the D-SNP is terminating the participant's enrollment in the Services My Way program, per notice provided in the first and second notices of non-compliance;
- iii. Informs the participant that he/she will be transitioned to agency-based personal care aide services, per notice provided in the first and second notices of non-compliance; and
- iv. Provides information regarding the participant's right to appeal the Services My Way program termination decision by filing an appeal with the Office of Administrative Hearings or through the D-SNP appeals process, if applicable.

B. Within five (5) business days of issuing the termination notice, the support broker contacts the participant/representative-employer and addresses the following topics:

- i. Reference to the first and second notices of non-compliance and the termination notice;
- ii. Review of the consequences of three (3) episodes of non-compliance;
- iii. Explanation of the process to transition the participant to agency-based personal care aide services; and
- iv. Explanation of the participant's right to appeal the Services My Way program termination decision and the appeal process.

Credible Allegations of Fraud, Theft, or Other Criminal Behavior -

In the case of a credible allegation of fraud, theft, or any other criminal behavior committed by a Services My Way participant, the participant is not referred to the remediation, training and termination protocol, and is not afforded three (3) episodes of non-compliance. The participant may be terminated from the program immediately upon completion of an investigation by DHCF's Division of Program Integrity or the D-SNP substantiating the credible allegation of criminal behavior.

A. If DHCF's Division of Program Integrity receives a credible allegation of fraud, theft, or any other criminal behavior by a Services My Way participant, the Division completes an investigation of the allegation and issues a report detailing its findings. If the report finds the allegation to be substantiated, DHCF then convenes a termination committee comprised of staff from multiple divisions as well as executive management to review the report and determine whether to terminate the participant based on the findings documented in the report. In cases where such an allegation concerns a Services My Way participant enrolled in a contracted D-SNP, the D-SNP will be notified by DHCF at the earliest possible opportunity.

B. If a contracted D-SNP receives a credible allegation of fraud, theft, or any other criminal behavior by an enrolled Services My Way participant, the D-SNP notifies DHCF, completes an investigation of the allegation, and issues a report detailing its findings. If the report finds the allegation to be substantiated, the D-SNP, in consultation with DHCF, convenes a termination committee to review the report and determine whether to terminate the participant from Services My Way based on the findings documented in the report.

C. If a participant is terminated from the Services My Way program under these circumstances, DHCF sends a termination notice to the participant/representative-employer, the support broker, and the waiver case manager or D-SNP ICP, which:

- i. Clearly states that DHCF is terminating the participant's enrollment in the Services My Way program, due to a substantiated allegation of fraud, theft or other criminal behavior;
- ii. Explains the allegation, the investigation process, and the findings of the investigation, and includes a copy of the investigation report;

- iii. Explains the process to transition the participant to agency-based personal care aide services, if appropriate; and
- iv. Provides information regarding the participant’s right to appeal the Services My Way program termination decision by filing a notice of appeal with the Office of Administrative Hearings.

If a participant files a timely appeal with the Office of Administrative Hearings or D-SNP following receipt of the termination notice, then while the appeal is pending, the participant remains enrolled in the Services My Way program and continues to receive those PDCS services and individual-directed goods and services included in the participant’s approved PDS budget.

Transition Safeguards -

The following safeguards are in place to ensure continuity of services and protect participant health and welfare during the transition: The transition to agency-based personal care aide services only occurs following receipt and explanation of the termination notice and the completion of any ensuing appeal(s) of the termination decision. Within five (5) business days of issuing the termination notice, the support broker contacts the participant to discuss the process for transitioning to agency-based personal care aide services with support from the waiver case manager or D-SNP ICT. As in the case of voluntary termination, the waiver case manager or D-SNP ICT is responsible for guiding the participant through the transition process and for coordinating the approval of the request to initiate agency-based personal care aide services. The waiver case manager or D-SNP ICT ensures there is no break in service and monitors participant health and welfare during the transition.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	<input type="text"/>	<input type="text" value="1400"/>
Year 2	<input type="text"/>	<input type="text" value="1600"/>
Year 3	<input type="text"/>	<input type="text" value="1800"/>
Year 4	<input type="text"/>	<input type="text" value="2000"/>
Year 5	<input type="text"/>	<input type="text" value="2200"/>

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

--

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

Recruit staff

Refer staff to agency for hiring (co-employer)

Select staff from worker registry

Hire staff common law employer

Verify staff qualifications

Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

Each potential PDW completes and pays for the combined FBI and District of Columbia criminal background check. Completing and passing the combined criminal background check is a condition of employment as a PDW. The criminal background check will be facilitated by the VF/EA FMS entity. If a PDW does not pass the required criminal background check, the participant/representative employer and DHCF or the D-SNP are notified.

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Each potential PDW completes and pays for the combined FBI and District of Columbia criminal background check. Completing and passing the combined criminal background check is a condition of employment as a PDW. The criminal background check will be facilitated by the VF/EA FMS entity. If a PDW does not pass the required criminal background check, the participant/representative employer and DHCF or the D-SNP are notified.

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Benefits to PDWs include the payment of Medicare and Social Security taxes (FICA), federal and state unemployment insurance taxes, and workers compensation insurance coverage, as well as any other benefits specifically required by DC or federal law as of the effective date of this renewal.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The participant-directed services (PDS) budget is developed based on the following methodology:

- (1) A PCSP is developed based on a comprehensive assessment for long term care services and supports, consultation with the participant and/or his/her representative(s), and consideration of the participant's care goals, preferences, and support needs. The process for PCSP development is the same for all waiver participants, regardless of whether they use PDS or provider-managed/agency-based services.
- (2) After the total authorized hours per day or week have been determined during the service planning process, the total PDCS hours per month are multiplied by the current rate of payment for agency-based PCA services.
- (3) The total dollar amount computed is then reduced by a pre-determined percentage to reflect the administrative overhead amount included in the agency-based PCA rate.
- (4) The resultant dollar amount represents the participant's PDS monthly allocation amount, which will be used to compute his/her PDS budget.

The participant's PDS budget is developed by the participant/representative-employer and the support broker as follows:

- (1) The PDS budget contains two cost components: PDCS labor and individual-directed goods and services.
- (2) The participant determines the wage rate paid to the PDW(s) based on the wage range prescribed by DHCF, which shall be no less than the DC living wage and no more, including employment taxes and insurance amounts, than the current rate paid for agency-based PCA services.
- (3) Individual-directed goods and services will be determined based on available funds remaining in the PDS budget after the PDCS budget amount is determined.

This methodology will be used to determine PDS budgets for all participants.

DHCF's or the D-SNP's budget template provides the participant's PDS monthly allocation amount, calculated using the methodology described above, to the participant/representative-employer and the support broker. The participant/representative-employer then works with the support broker to determine how the PDS budget will be developed to best serve the participant's needs while maintaining his/her health and welfare.

For fee-for-service participants, the support broker submits the PDS budget to DHCF, which must approve all PDCS and individual-directed goods and services requested in the budget. Once approved, the PDS budget is provided to the VF/EA FMS-Support Broker entity, which must pay PDWs for approved PDCS services rendered and invoices from vendors for approved individual-directed goods and services in accordance with the PDS budget.

For D-SNP participants, the budget is reviewed and approved consistent with the D-SNP's established utilization management and care management policies and procedures for the PDS population, which are subject to review, approval, and ongoing monitoring by DHCF.

Information about the PDS budgeting process is available through the outreach and training materials provided by DHCF and its agents and is accessible to the public via the DHCF website.

Beginning state fiscal year 2023, DHCF will make supplemental budget allocations to strengthen the direct service workforce and increase the pay of PDWs who are likely to be paid at or near the minimum/living wage for delivering participant-directed community support services.

Supplemental budget allocations may be made in addition to the base PDS budget one time per fiscal year. The VF/EA FMS- Support Broker entity will ensure that the PDS budget is adjusted to include the supplemental budget allocation at the discretion of the participant/employer and only if the following criteria are met within the budget period:

- (1) The participant/employer has purchases or has been approved to purchase individual-directed goods and services;
- (2) The participant/employer has budgeted and been approved for an overtime (OT) hourly rate of pay for at least one (1) PDW, and the hourly wage for hours worked up to forty (40) hours per week is at or near the minimum/living wage; and/or
- (3) The participant/employer has more than one (1) PDW, and the average hourly rate of pay among all PDWs is at or near the minimum/living wage.

The VF/EA FMS- Support Broker entity will be responsible for ensuring only those who meet the above criteria,

based on the currently approved PDS budget, qualify for the supplemental budget allocation and will ensure that the payment is dispersed as directed by the participant/employer.

District funds equivalent to the federal funds attributable to the increased Federal Medical Assistance Percentage authorized under Section 9817 of the American Rescue Plan Act of 2021 are used to fund the non-federal share of the supplemental budget allocations. Unused portions of the PDS budget, including any supplemental budget allocations, are not disbursed at the end of the service plan period and do not roll over to subsequent service plan periods.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

As detailed above, DHCF's budget template provides the PDS monthly allocation amount to the participant/representative-employer and the support broker, who then develop a detailed PDS budget based on the monthly allocation amount.

If the participant's needs change at any time, the participant, with assistance from the support broker and authorized representative, if applicable, may request an adjustment to the PDS budget. DHCF or the D-SNP will provide the participant, the support broker, and the authorized representative, if applicable, with written notice of the approval or denial of the request. If the participant disagrees with DHCF's or the D-SNP's determination, the participant may request a redetermination of the request. The participant also has the right to appeal the determination by filing an appeal with the Office of Administrative Hearings or through the D-SNP, as applicable.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one:*

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the

premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

DHCF has implemented a number of safeguards to prevent the premature depletion of the PDS budget and address potential service delivery problems that may be associated with budget underutilization.

(1) The VF/EA FMS entity prepares and issues a monthly PDS budget report to participant/representative-employers, support brokers, waiver case managers and D-SNP ICTs, and DHCF or the D-SNP, as applicable. This report provides the PDS budget amount, services used, and expenditures incurred for the current month and year to date, as well as the remaining balance. The support broker reviews this report with the participant/representative-employer as needed and addresses any questions.

(2) The VF/EA FMS entity monitors PDCS utilization by pay period. The VF/EA FMS entity issues a report to the participant/representative employer, the support broker, the waiver case manager or D-SNP ICT, and DHCF or the D-SNP, as applicable, if significant over- or under-utilization of PDCS services is found. The support broker reviews the report with the participant/representative employer and addresses any questions. If over-utilization of PDCS services is found, the VF/EA FMS entity collects the amount of the overage from the participant/representative-employer. Significant over-utilization of PDCS services is considered an episode of non-compliance with the terms of the Participant/Representative-Employer Agreement and results in referral of the participant/representative-employer to the remediation, training, and termination protocol detailed above, which requires the participant/representative employer to prepare a CAP detailing how the participant/representative employer will remedy the issue.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The beneficiary freedom of choice form specifies that the participant has the right to choose to reside in an institutional setting or a home and community based setting. It is also documented in the form that the participant has the right to choose which provider to use. A list of current approved providers is given to the participant (or his/her authorized representative) to choose from.

Any waiver applicant/participant aggrieved by DHCF's action or inaction, which affects his/her participation in the EPD Waiver program or the level of benefits received under the EPD Waiver program, may request a fair hearing. During the application and recertification process for the waiver, the Economic Security Administration (ESA) sends written notice of the eligibility determination to waiver applicants/participants on a standard form which contains an explanation of the applicant/participant's right to request a fair hearing regarding his/her EPD Waiver eligibility. In addition, applicants/participants are provided with the process for requesting such a hearing, the right to present witnesses, the right to be represented by legal counsel or other spokespersons of choice, the right to have reasonable expenses related to the hearing paid by the District of Columbia Government, and that legal services are available to the applicant/participant. The written notice also informs the applicant/participant of his/her right to continue to receive EPD waiver services during the appeal process if he/she requests a fair hearing before the effective date of the adverse action.

All enrolled waiver participants may request a fair hearing when their EPD Waiver services are denied, suspended, reduced, or terminated. A hearing request is an expression, oral or written, by the participant or his/her representative that:

- The participant wishes to appeal a decision of DHCF; and
- The participant wants an opportunity to present his/her case at the Office of Administrative Hearings (OAH).

The request for a hearing must be filed within 90 days of the date of the notice to either OAH or the Office of Health Care Ombudsman. The request for a hearing may be made verbally or in writing.

All waiver applicants will be afforded the right to request a hearing if they are not notified of a decision on their application for the EPD Waiver Program within the time allowed. In addition, at any time during the certification period, a participant may request a fair hearing to dispute his current level of benefits under the EPD Waiver Program.

If the applicant/participant requests a fair hearing before the effective date of the proposed adverse action, services under the EPD Waiver program must be continued at the previous level unless the applicant/participant specifically waives continuation of services under the EPD Waiver program. DHCF shall implement the adverse action during the appeal only if the applicant/participant requests in writing that the adverse action be allowed to take effect pending the outcome of the appeal. DHCF shall not permit the adverse action to become effective if the following criteria are met:

The waiver participant requests the fair hearing before the effective date of the adverse action or within 15 days of the postmark date on the notice of adverse action, whichever is later. Medical assistance shall be continued at the previous level unless the waiver participant specifically waives continuation of Medical assistance.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

DHCF's Long Term Care Operations Division within LTCA is responsible for the operation of the grievance/complaint system. Additionally, the District of Columbia Office of Health Care Ombudsman and Bill of Rights (OHCOBR), an independent office located within DHCF, operates a separate complaint resolution system, through which waiver participants may also make complaints. LTCA and OHCOBR coordinate on the resolution of all types of complaints, including those related to this waiver, and to facilitate the development of program improvements to address underlying systemic issues that may have led to complaints.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) Participants may make all types of complaints or grievances to DHCF pertaining to the provision of waiver services. These include, but are not limited to, complaints about: denial or reductions of service; the process or results of their waiver eligibility determination; poor timeliness or quality of care; restriction of their rights; lack of or interference with choice of provider; issues related to the waiver waiting list, if applicable; patient abuse, neglect, or exploitation by waiver providers; and violations of patient privacy or confidentiality. All complaints about abuse, neglect, or exploitation by waiver providers will follow the EPD Waiver Incident Management process.

(b) The timelines for resolving complaints are as follows. All complaints that indicate that a participant's health and/or welfare are at immediate risk are addressed within 24 hours or next business day of the receipt of the complaint. Complaints pertaining to Medicaid eligibility determination and denial or reduction of service are addressed within seven (7) business days; all other complaints are addressed within ten business days and resolved within thirty (30) days of the receipt of the complaint. If the complaint remains unresolved after the third week, it is elevated to LTCA management for further intervention. If after thirty (30) days the complaint remains unresolved, it is elevated to the LTCA Director for intervention. Complainants are also informed upon the initiation of the complaint of the right to a fair hearing and how to obtain one.

(c) When a participant, or advocate authorized by the participant, contacts the LTCA, the complaint is documented and logged into a cloud-based, electronic complaints management system and assigned to one of several staff persons in the LTCA for investigation and resolution. These staff investigate and use a variety of processes and mechanisms to resolve the complaint, depending upon the nature of the complaint. These processes and mechanisms include, but are not limited to: interviewing the participant, participant representative, service provider, and others with knowledge of the problem to obtain a clear understanding of the problem; reviewing the participant's service records and provider documentation; and reviewing billing records. Once the problem is well understood, staff can take a number of actions as appropriate including: directing the provider to develop and implement a corrective action plan (to be approved by LTCA staff); assisting the participant to choose another provider and transfer to that provider; referring the situation to Adult Protective Services or other intergovernmental resources; referring the situation to the DHCF Division of Program Integrity when instances of provider fraud or abuse are suspected; and referring complainants to the fair hearing process when certain complaints are not resolvable to the complainant's satisfaction or involve issues pertaining to eligibility for or denial of services.

In addition to the LTCA complaints receipt and resolution process, the Office of Health Care Ombudsman and Bill of Rights (OHCOBR) manages its own complaints process. The OHCOBR is comprised of two legislative requirements, the Ombudsmans Program (D.C. Code § 7-2071.01 et seq.), and the Grievance Procedures for Health Benefit Plans (D.C. Code § 44-301.01 et seq.). In February, 2008, the D.C. Medical Assistance Administration of the D.C. Department of Health (DOH) became a separate, cabinet-level agency, DHCF, for the administration of the Medicaid program (D.C. Code § 7-771.01 et seq.) and obtained jurisdiction over matters pertaining to both requirements. These laws, regulations, and policies pertaining to complaints and grievances are available to CMS upon request.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including

alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The District recognizes two categories of incidents: serious reportable and reportable incidents.

A Serious Reportable Incident (SRI) is a significant event or situation which due to its severity requires immediate response, notification to, and internal review and investigation by the provider agency and/or DHCF. SRIs include, but are not limited to: death; abuse; neglect; exploitation; theft of consumer personal property; serious physical injury; inappropriate or unauthorized use of restraints; suicide attempt; and serious medication error.

A Reportable Incident (RI) is a significant event or situation involving a participant and shall be reported to DHCF, and investigated by the provider. RIs include, but are not limited to: medication error; missing person; hospitalization; suicide threat; vehicle accident; fire; police; emergency room visit; emergency relocation; property destruction; and, other events or situations that involve harm or risk of harm to a participant.

All employees, sub-contractors, consultants, volunteers, or interns of an EPD waiver provider agency or government agency are required to notify DHCF within 24 hours (or the next business day) of occurrence, when a serious reportable incident or reportable incident is witnessed, discovered, or becomes known. Notifications are made via facsimile or reported electronically through DHCF's electronic case management system. All case management providers are required to electronically report incidents.

All contracted D-SNPs are responsible for managing reporting on adverse events, which include serious reportable incidents and reportable incidents. Contracted D-SNPs are required to report all serious reportable incidents, reportable incidents, and other adverse events to DHCF in a manner and frequency sufficient to enable comprehensive management and reporting of incidents across the entire EPD waiver.

In the event of a serious reportable or reportable incident the provider is required to document the incident on its internal incident report form and complete an internal investigation within five business days of the incident's occurrence. Furthermore, the provider is required to submit all incident report forms to DHCF's Long Term Care Administration (LTCA).

Additionally, for all serious reportable incidents involving unexplained death, neglect, abuse, exploitation, and theft of consumer personal property occurring at a participant's natural home, the provider is required to report the incident to the DHCF and the District of Columbia, Adult Protective Services (APS). Deaths that are expected and/or of natural causes are not required to be reported to APS.

With the exception of case management agencies, for all serious reportable and reportable incidents the provider is required to report the incident to DHCF and the District of Columbia, Department of Health/Health Regulation and Licensing Administration (DOH/HRLA). Case management agencies are not licensed by DOH/HRLA, and are therefore not required to report incidents to that entity. Further, all serious incidents involving death or criminal activity which occurs at an assisted living facility are reported by the provider to the District of Columbia, Metropolitan Police Department (MPD). These incidents include, but are not limited to abuse or theft of a waiver participant's property.

Incident data reported to DHCF is managed in the District's case management system by LTCA staff and aggregated by DHCF's Division of Quality and Health Outcomes (DQHO) for trends. Additionally, DQHO generates quarterly and ad hoc quality reports on incident management data as part of the District's quality improvement efforts.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Training and information are offered to participants and/or families or legal representatives in the following manner:

All participants and/or their family members/legal representatives are provided with information about the EPD Waiver including the protections and safeguards that are afforded them.

The District maintains an incident management policy and recommends to EPD waiver providers best practices to follow in the area of incident reporting and investigating, including how to identify and report abuse, neglect, and exploitation. Providers are required to develop internal protocols to ensure compliance with this policy. The protocols shall establish procedures, to include the responsibilities of employees, interns, volunteers, consultants and contractors with regard to identifying, reporting, investigating, addressing and monitoring follow-up of incidents.

On an annual basis, EPD waiver providers are required to train and educate participants regarding abuse, neglect, mistreatment and exploitation, and as part of enhanced quality expectations are expected to use naturally occurring opportunities throughout the year to reinforce the learning process.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Incident Management refers to the reporting and prevention of abuse, neglect, and exploitation of participants served in Medicaid-funded, home and community-based service programs. Incident Management also includes the reporting of participant involvement with law enforcement or emergency services; the reporting of environmental hazards that compromise the health and safety of a participant; and reporting the death of a participant.

LTCA ensures that all incidents submitted by waiver providers are adequately completed within 24 hours, or the next business day, of the incident being reported to the DHCF. When necessary, the designated staff contacts the provider to ensure that required notifications were made. The designated staff also verifies that all serious reportable incidents involving allegations of abuse, neglect, exploitation and theft of consumer personal property, where staff was alleged to be involved in the incident have been removed from contact with the participant until receipt by the DHCF of a satisfactory investigation from the provider.

All serious reportable incidents are investigated by the provider, submitted to DHCF and reviewed by DHCF to determine the need for additional follow up/remediation, or the need for an LTCA investigation. Reportable incidents are written on an incident report form, investigated by the provider and the investigation report is maintained within the clinical case management system and made available to all pertinent DHCF employees.

Follow up/ remediation action requested by DHCF in response to an investigation is to be implemented within ten business days of receipt of notice from DHCF. Any follow up/remediation action not addressed by the provider after receiving notice must be supported by and acceptable to DHCF. Further, when a provider fails to address follow up/remediation action, DHCF will recommend that the involved participant selects an alternate provider. Additional remediation action may be initiated by DC Health/HRLA.

The provider must report the outcome of an investigation to the participant and/or participant's family member(s)/legal representative within 3 business days of completion of an investigation.

Timeframes for reporting an incident can be changed or adjusted when there are health and safety concerns that require an immediate response.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

LTCA and DQHO share incident management data from the clinical case management system on an ongoing basis. DQHO evaluates trends of incident data and presents findings to LTCA for needed follow up with providers.

The oversight and monitoring team review reported incidents on a monthly basis to identify individual and provider patterns/trends and to ensure that providers are managed as per DHCF's policy and procedures. As needed, LTCA staff from oversight and monitoring team generates discoveries to providers and for follow up and resolution. Additionally, oversight and monitoring staff analyze incident tracking on a quarterly basis and make recommendations to operations staff for systemic improvement on incident management. DHCF provides ongoing, routing training to provider agencies during provider meetings and calls.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The District of Columbia Assisted Living Residence Regulatory Act of 2000 (ALR) prohibits the use of restraints and restrictive interventions in Assisted Living Facilities. In addition, ALR also references the sanctions and remedies which are outlined in the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983. The DC Health Regulatory Licensing Agency (HRLA) monitors Assisted Living facilities for use of restraints and/or other restrictive interventions. Oversight is conducted via routine annual surveys, surveys triggered by complaints or incidents, and more frequently when deficient practices are detected, as stipulated in the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983. Interviews also occur with patients, family, direct care staff, health care delivery teams. Reviews are conducted more frequently based on severity and frequency of complaints.

Any detected violations of the prohibition on use of restraints and restrictive interventions in Assisted Living Facilities are reported to the state Medicaid agency. DHCF has formalized these processes through a Memorandum of Understanding (MOU) with DC Health, in effect since 2016. The MOU specifies that DC Health-HRLA shall supply DHCF with the reports that contain details about deficiencies and the imposition of any sanctions consistent with District statutory and regulatory authority.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

DC Health's Health Regulatory Licensing Agency (HRLA) is responsible for the monitoring of unauthorized use of restraints and/or seclusion on an annual basis, at a minimum.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

DHCF's and its contracted D-SNPs conduct initial provider screening, credentialing, and readiness reviews to ensure provider qualifications. These include policies and procedures around maintaining the waiver participant's health, safety, and welfare. The District strictly prohibits the use of unauthorized use of seclusion. Waiver provider and D-SNP staff, including HHAs' supervisory nurses, D-SNP ICT staff, and case managers monitor the participant in order to detect any unauthorized use of seclusion. If detected, an incident report is completed by the staff discovering such use. The incident is reported to DHCF who in turn, reports to DC Health for further review and investigation.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. Applicability.** Select one:

No. This Appendix is not applicable *(do not complete the remaining items)*

Yes. This Appendix applies *(complete the remaining items)*

- b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the state:

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

- iv. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. **Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.** (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

(16)G.a.1 Percent of participants' serious reportable incidents reported within 24 hours or next business day of notification. Numerator= Number of participants' serious reportable incidents reported within 24 hours or next business day.

Denominator= Number of serious reportable incidents reported.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

(18)G.a.3Percentage of substantiated serious reportable incidents(abuse, neglect, exploitation, unexplained death) resulting in development & implementation of prevention strategies. N=# of substantiated serious reportable incidents(abuse, neglect, exploitation, unexplained death) resulting in development & implementation of prevention strategies. D=# of substantiated serious reportable incidents.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1061 1264 1144" type="text"/>
Other Specify: <input data-bbox="408 1290 644 1330" type="text"/> Contracted D-SNPs	Annually	Stratified Describe Group: <input data-bbox="1078 1285 1264 1368" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1509 1264 1592" type="text"/>
	Other Specify: <input data-bbox="718 1733 954 1816" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

(17)G.a.2 Percentage of all participants' serious reportable incidents with investigations initiated within 48 hours. Number of all participants' serious reportable incidents with investigations initiated within 48 hours (numerator). Number of all serious reportable incidents investigated (denominator).

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other	Annually	Stratified

Specify: <input type="text" value="Contracted D-SNPs"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

b. Sub-assurance: *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

(21)G.b.3 Percentage of beneficiaries’ serious reportable incidents where follow-up was implemented within 30 days of closure of investigation. Number of beneficiaries’ serious reportable incidents where follow-up was implemented within 30 days of closure of investigation (numerator). Number of serious reportable Incident investigations that were closed/completed (denominator).

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="90%"/>
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

(20)G.b.2 Percentage of beneficiaries with complaints investigated with-in 7 days.
Number of beneficiaries with complaints investigated with-in 7 days (numerator).
Total Number of complaints (denominator).

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other	Annually	Stratified

Specify: <input type="text" value="Contracted D-SNPs"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

(19)G.b.1 Percentage of serious reportable incident investigation outcomes notified to the person within 3business days of closure of investigation. N= Number of serious reportable incident investigations where beneficiary and/or representative was notified of outcome within 3business days of investigation's closure.D= Number of serious reportable incident investigations that were completed/closed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">90%</div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">Contracted D-SNPs</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

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

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

Performance Measure:

Percentage of unapproved restrictive interventions with a prevention plan developed as a result of the incident. N= Number of unapproved restrictive interventions with a prevention plan developed as a result of the incident / D= Number of incidents with unapproved restrictive interventions.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		<input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

d. Sub-assurance: *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

Performance Measure:

(22)G.d.1 Percentage of beneficiaries that received an annual preventive health visit.

N= Number of beneficiaries who received an annual preventive health visit. D=

Number of beneficiaries who were due for a preventive health visit.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1317 1262 1397" type="text"/>
Other Specify: <input data-bbox="411 1541 644 1581" type="text" value="Contracted D-SNPs"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1541 1262 1621" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1765 1262 1845" type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

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

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

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

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

The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF.

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

The DQHO partners with LTCA to conduct comprehensive review for assessing the overall performance of the EPD Waiver. It includes an iterative process for assessing performance, identify opportunities for improvement and outline recommendations for targeted quality improvement processes and measuring and monitoring the program's overall effectiveness. Additionally, all applicable providers shall be subject to quality standards, including but not limited to, guidance issued by the Centers for Medicare and Medicaid Services (CMS) and rules issued by DHCF's quality improvement activities. In line with these requirements.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The DLTC EPD has monitoring staff who conduct a review of the provider from which the complaint originated and subsequently triages complaints to identify and investigate the nature of the complaint and refers it to the appropriate regulatory agency. Specifically, if a complaint occurred within a specific provider agency and that agency did not initiate an internal timely investigation, then DHCFs CLTC monitoring unit would send the provider agency a deficiency report and refer it to the appropriate agency for follow-up, ie. Program Integrity, HRLA, Adult Protective Services, etc.

When DHCF detects problems in Health and Welfare, it has several sequential strategies it will use to address them. These include:

- 1) Meeting with providers (individually or as a group) to deliver education to correct the detected problems. This will most often be used for a first-time occurrence of a problem of a specific type. Meetings will be conducted by staff from LTCA. If a problem is detected across multiple providers, DHCF will send an official written transmittal to all providers describing the problem and how DHCF requires it to be addressed. Documentation of these efforts will be made by LTCA as notes on individual providers, notes on the agenda of monthly provider meetings, or as copies of the transmittals.
- 2) Problems that recur will be addressed through additional training and the delivery of a written notice from DHCF requiring the correction of the problem. LTCA is responsible for documenting the remediation process with individual providers and retains documentation.
- 3) Problems that persist will be addressed through more stringent means including the recoupment of Medicaid payments associated with claims related to the service plan problem. Such recoupments are handled by DHCFs Office of Utilization Management which maintains records of all such recoupments.
- 4) Serious and /or repeated violation of standards for service planning can result in termination of the provider in accord with DHCFs Administrative regulations. Provider terminations are handled by DHCFs Office of Program Integrity which maintains documentation of all such provider actions.

ii. Remediation Data Aggregation

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

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="Contracted D-SNPs"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

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

No

Yes

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

As mentioned under question ii (Methods for Discovery), DHCF has in place several mechanisms to monitor and analyze EPD waiver performance. The LTCA Oversight and Monitoring Division conducts compliance reviews on performance measures of all waiver assurances. The LTCA Oversight and Monitoring Division is responsible for the discovery and remediation process of individual and systemic issues. The findings from the Oversight and Monitoring are shared with the providers with a request for Opportunity for Improvement Action Plan (OFIP) and continuous quality improvement efforts to prevent recurrence of such findings.

The District's DQHO has a Program Analyst dedicated to the LTCA and the EPD waiver. This Program Analyst has assisted in development and implementation of an EPD work plan to ensure that all elements of the waiver are in compliance. The Analyst also chairs a Quality Management Committee meeting on a monthly basis that implements the Quality Strategy outline in Appendix H including a Continuous Quality Improvement plan. This process includes the development of Quality Improvement Projects for any assurance that is performing below 86%.

Specifically related to the timeliness of investigations, the oversight and monitoring team review the reported incidents on a monthly basis to identify individual and provider patterns/trends and to ensure that providers are managing incidents investigations as per DHCF's policy and procedures. The LTCA staff from oversight and monitoring team generate discovery to the providers that are not managing incidents for plan of action and follow up. Additionally, the oversight and reporting team analyze the incident tracking on a quarterly basis and make recommendations to the operations division for systemic improvement on incident management

The District has reviewed with the providers the importance on incident management and its follow up during the monthly provider leadership meetings and this has resulted in the timeliness of investigations measure to increase by twenty-one percentage points from WY5 QTR1 at 27% to WY5 QTR3 at 48%.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state

spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The District has a system of Continuous Quality Improvement to ensure that all requirements outlined within the waiver are met. The LTCA and the DQHO works together to develop performance measure indicators ensuring the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The District reviews aspects of the waiver for compliance and when it is found that there is not compliance the District issues a discovery for each individual instance of non-compliance. Each individual discovery is remediated on an individual basis. The District evaluates the system as a whole and anytime that the system is performing at below 86%, it is determined there is a need for a Quality Improvement Project (QIP). The only time a QIP is not implemented is the District believes there is justification and CMS approves this justification. The impact of QIPs will be analyzed to determine efficacy and if they are not found to be effective a new barrier analysis will be conducted and or new interventions developed.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify:	Other Specify:

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
Contracted D-SNPs	

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

BILLING AND CLAIMS:

The effectiveness of any system change is measured by assessing whether the changes truly function as designed and whether the design produced the anticipated results. HCOA is responsible for ensuring that changes made to the MMIS are in line with the agreed upon design. Once a change is implemented in production ACS monitors the change and captures three instances where the change worked as designed. A CSR can only be closed once the proof in production requirement has been satisfied.

In order to assess whether the design is producing the anticipated results, reports are often created that allow program staff to monitor progress. Reports can be created on an ad hoc basis or put into production as a standard daily, weekly, monthly, quarterly or annual report. All standard reports are placed in a web based reports repository called Reports On Line (ROL) that is accessible via the secure portion of the DHCF web portal. DHCF employees are provided access to the secure portion of the web portal via user names and passwords.

In addition to canned reports certain DHCF staff members have access to a Cognos database that can be used to access data directly and generate custom reports in real time. HCOA works closely with program staff to ensure that the database contains the data elements needed to perform proper analysis and that data is being interpreted correctly.

The District's DQHO has a Program Analyst dedicated to the LTCA and the EPD waiver. This Program Analyst has assisted in development and implementation of an EPD work plan to ensure that all elements of the waiver are in compliance. The Analyst also chairs a Quality Management Committee meeting on a monthly basis that implements the Quality Strategy including a Continuous Quality Improvement plan.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DHCFs DQHO conducts an evaluation of the waiver program that includes recommendations that is presented at the QMC annually. The DHCF Quality Strategy is updated at this time if appropriate.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (Please provide a description of the survey tool used):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Financial integrity is promoted through pre- and-post payment processes. Pre-payment activities are described in section I-2-d Billing Validation Process. Per the enrollment process outlined in Appendix C, Provider Specification, providers are required to secure an independent financial statement audit.

However, the State Agency is required to perform post payment audits under Chapter 42 of Title 29, DC Municipal Regulations (29 DCMR § 4236). To fulfill this requirement, a random sample of claims for selected waiver services is annually audited by the State Agency's Division of Program Integrity - Surveillance and Utilization Branch. The random sample size is determined using the industry standard statistical software package, RAT-STATS. The standard sample period is one year, although there may be deviation based on the size and scope of the provider under review. The District uses attribute sample size determination. In the sampling methodology, the universe is based on claims paid.

These audits compare information submitted on the claims to patient care documentation and assess whether or not the services billed for are: included in the participant's approved service plan, were provided, and meet other requirements of the waiver. In instances in which claims appear to be unsubstantiated, the state agency begins a recoupment process and returns the federal share, when recoupment is upheld through reconsideration and appeals processes, consistent with federal regulations. On-site reviews will be conducted when data analysis, previous interactions with the provider, complaints, or other information provide indications there may be concerns with the timeliness of response by the provider, lack of response, or potential for modification of records. For on-site audits DPI, normally DPI uses a confidence level of 90 and precision range of 15, although based on discussions with DHCF's Office of General Counsel and in accordance with DPI policy, DPI will utilize one of the following combinations dependent on case specifics:

- Confidence Level 95 and Desired Precision Range 10*
- Confidence Level 90 and Desired Precision Range 10*
- Confidence Level 90 and Desired Precision Range 15*
- Confidence Level 90 and Desired Precision Range 20*

For desk audits, DPI uses 100% claims evaluation for known outliers, such as home health services, services exceeding service limits, and concurrent delivery of services, for a specific time-period (normally fiscal or calendar year). Several types of services are specifically prohibited in District/Federal regulations across multiple or individual service categories. In the District's Division of Program Integrity, audits are generally conducted by SURS or the Surveillance and Utilization Branch and investigations by the Investigations Branch. Division of Program Integrity management monitors the activities of the branches to ensure there is no duplication of efforts, in addition bi-weekly meetings are held to complete collaboration on activities and to coordinate efforts as needed.

SURS audits and LTCA's EPD Waiver Oversight and Monitoring reviews use the same sampling methodology, although the areas of focus are different. There are approximately 40 providers in the waiver program. All providers are subject to post-payment review, although DHCF focuses on claims evaluation for known outliers.

Random sampling of such claims is an efficient approach to validation and ensuring appropriate payment recovery because the rate of denied claims in the sample can be applied to the universe of similar claims from the provider and a percent of payment equal to the error rate observed in the sample can be recovered. Also, providers identified as receiving an overpayment are required to provide a plan of correction which is included in all proposed notice of overpayment letters. A spreadsheet is maintained to track audits, including the submission of plans of correction. Additional notification is provided to non-complaint providers. As part of the normal Surveillance and Utilization Review process, past behavior of selected providers are reviewed including submission and compliance with plans of correction.

In addition, the District of Columbia Office of the Inspector General conducts audits, as indicated.

Finally, every year, the entire Medicaid grant, including the portions funding the EPD Waiver, is audited as part of the Single Audit of all the federal grants awarded to the District. The Office of Integrity and Oversight within the Office of the Chief Financial Officer (of the District) oversees the Single Audit. In FY2015 the single audit was conducted by BDO USA, LLP.

The DHCF's Division of Program Integrity shall perform ongoing audits and post-payment reviews. DHCF's Long Term Care Administration's EPD Waiver Monitoring/Oversight team shall also conduct ongoing reviews of providers to ensure adherence with various programmatic standards. Both processes are outlined below in accordance with the EPD Waiver's proposed regulations.

Please see Appendix E(i)(iv) for a description of the post-payment review processes specific to the VF/EA FMS-Support Broker entity for the Services My Way program.

The satisfaction survey is conducted sixty (60) days after a participant's enrollment into the Services My Way program. The survey is comprised of seven (7) questions related to the VF/EA FMS-Support Broker entity enrollment process and ongoing services. If a participant/representative employer indicates an area of dissatisfaction on the survey, DHCF contacts the VF/EA FMS-Support Broker entity to communicate the issue and request additional information depending on the type of complaint. If the complaint is directly related to the VF/EA FMS-Support Broker entity's customer service, the issue is resolved by the contract administrator, who is responsible for ensuring the VF/EA FMS-Support Broker entity's compliance with all terms of its contract. If the survey results indicate that the VF/EA FMS-Support Broker entity is not meeting the service delivery standards set forth in the contract, DHCF will require the entity to remediate the issue(s) and the entity may be found in breach of its contract with DHCF.

AUDITS AND MONITORING/OVERSIGHT REVIEWS

The DHCF's Division of Program Integrity shall perform ongoing audits to ensure that the provider's services for which Medicaid payments are made are consistent with programmatic duties, documentation, and reimbursement requirements as required under Chapter 42 of Title 29 of the DCMR.

The audit process shall be routinely conducted by DHCF to determine, by statistically valid scientific sampling, the appropriateness of services rendered to EPD Waiver program beneficiaries and billed to Medicaid.

Each EPD Waiver provider shall allow access, during an on-site audit or review (announced or unannounced) by DHCF, other District of Columbia government officials, and representatives of the United States Department of Health and Human Services, to relevant records and program documentation.

The failure of a provider to timely release or to grant access to program documents and records to the DHCF auditors, after reasonable notice by DHCF to the provider to produce the same, shall constitute grounds to terminate the Medicaid Provider Agreement.

If DHCF denies a claim during an audit, DHCF shall recoup, by the most expeditious means available, those monies erroneously paid to the provider for denied claims, following notice and the period of Administrative Review set forth in accordance with EPD regulations.

The recoupment amounts for denied claims during audits shall be determined by the following formula:

(a) The number of denied paid claims resulting from the audited sample shall be divided by the total number of paid claims from the audited sample; and

(b) The amount derived from (a) shall be multiplied by the total dollars paid by DHCF to the provider during the audit period to determine the amount to be recouped. For example, if a provider received Medicaid reimbursement of ten thousand dollars (\$10,000) during the audit period, and during a review of the claims from the audited sample, it was determined that ten (10) claims out of one hundred (100) claims are denied, then ten percent (10%) of the amount reimbursed by Medicaid during the audit period, or one thousand dollars (\$1000), would be recouped.

DHCF shall issue a Notice of Proposed Recovery for Medicaid Overpayment (NPRMO) which sets forth the reasons for the recoupment, including the specific reference to the particular sections of the statute, rules, or Provider agreement, the amount to be recouped, and the procedures for requesting an administrative review.

The timelines for responding to the NPRMO and the provider's appeal rights are governed under Chapter 42 of Title 29 of the DCMR.

In addition to audits, the DHCF's Long Term Care Administration's EPD Waiver Oversight and Monitoring team shall conduct two types of reviews:

(a) Annual oversight and monitoring reviews to ensure compliance with established federal and District regulations and applicable laws governing the operations and administration of the EPD Waiver Program; and

(b) Quarterly compliance reviews to ensure adherence with the EPD Waiver Program's performance measures.

Each waiver services provider shall allow the EPD Waiver oversight and monitoring team access, during an on-site

oversight/monitoring process (announced or unannounced).

As part of the oversight and monitoring process, providers shall grant access to any of the following documents, which may include but shall not be limited to the following:

- (a) Person-Centered Service Plan (PCSP) and Plan of Care/ service delivery plan;
- (b) Employee records;
- (c) A signed, and current copy of the Medicaid Provider Agreement;
- (d) Licensure information;
- (e) Policies and Procedures;
- (f) Incident Reports and Investigation Reports; and
- (g) Complaint related reports.

DHCF's EPD Waiver Oversight and Monitoring Team shall issue a Statement of Findings and Opportunities for Improvement Plan ("improvement plan") within fifteen (15) calendar days of the annual oversight and monitoring exit meeting. Providers shall submit a plan of correction within fifteen (15) calendar days of the date of receipt of DHCF's improvement plan

DHCF's EPD Waiver Oversight and Monitoring team shall generate a performance measures discovery/remediation report ("remediation report") within five (5) business days of completion of the quarterly performance measures-related review. Providers shall submit a performance measures-related remediation plan ("remediation plan") within ten (10) business days of receipt of the report.

The failure to provide an acceptable plan of correction, remediation plan or adherence to the improvement plan or remediation report, may result in a prohibition of new admissions, referral to the DHCF's Division of Program Integrity for further investigation or imposition of a sanction or termination of the Medicaid Provider Agreement.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

- a. **Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

Performance Measure:

(23)I.a.1 Percentage of claims reviewed by program integrity audits that failed standards. Number of waiver service claims reviewed by program integrity audits that met standards (numerator). Number of claims reviewed by program integrity for audits (denominator).

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS; Contracted D-SNPs

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Confidence Interval of no less than 90% with an error rate of no greater than 20 </div>
Other Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Contracted D-SNPs </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: auto; margin-right: auto;"></div>
	Continuously and Ongoing	Other Specify:

		<p><i>dependent on case specifics one of the following:</i> <i>Confidence Level 95/Error rate 10</i> <i>Confidence Level 90/Error rate 10</i> <i>Confidence Level 90/Error rate 15</i> <i>Confidence Level 90/Error rate 20</i></p>
	<p>Other Specify:</p> <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<p>Other Specify:</p> <input type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<p>Other Specify:</p> <input type="text"/>

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:

(24)I.b.1 Percentage of waiver claims reviewed that were paid using the correct rate as specified in the waiver application. Number of waiver claims reviewed that were paid using the correct rate as specified in the waiver application/ D= Number of waiver claims reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Confidence Interval of no less than 90% and an error rate no greater than 20 </div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify:

		dedependent on case specifics one of the following: Confidence Level 95/Error rate 10 Confidence Level 90/Error rate 10 Confidence Level 90/Error rate 15 Confidence Level 90/Error rate 20
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
Other Specify: <input type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	Other Specify: <input type="text"/>

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

In addition, scheduled reporting to CMS using 372 cost neutrality formulas provides opportunities for review, analysis, detection, and refinement.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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

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

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

The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF.

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

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

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

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

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="320 465 794 506" type="text" value="Contracted D-SNPs"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="866 703 1340 786" type="text"/>

c. Timelines

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

No

Yes

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

As mentioned above under question ii (Methods for Discovery), DHCF has in place several mechanisms to monitor and analyze EPD waiver performance. The LTCA Oversight and Monitoring Division conducts compliance reviews on performance measures of all waiver assurances. The LTCA Oversight and Monitoring Division is responsible for the discovery and remediation process of individual and systemic issues.

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

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

The performance status for each measure is discussed at the monthly QMC meeting. Committee members include managers and staff within various administrations at DHCF. Additionally, DHCF utilizes a work plan that tracks performance and prioritizes improvement efforts and implementation of the Plan-Do-Check-Act quality improvement process. The work plan will be utilized to formally develop the written quality strategy. This strategy will be in compliance with CMS's national initiatives for home and community based settings. This strategy will be aligned with the National Quality Strategy of better care, healthy people, healthy communities, and affordable care. This program will fit within the Agency's strategic mission and strategic goals.

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

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

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Provider payment rates are uniform for every provider. DHCF elicits public comments through District rule-making process, and information regarding payment rates are available to waiver participants via publication of proposed and ratified rules. Office of Rates, Reimbursement and Financial Analysis (ORRFA) is responsible for rate development with assistance from LTCA/EPD Branch. Rate information is available to Medicaid participants and community members upon request and on DHCF website at <http://dhcf.dc.gov>. Meetings are held with providers, community stakeholders, to assess outstanding waiver issues, and discuss rates and rate structure for direct care workers (PCA) and review assessment of expertise and capacity of providers and services.

Rate structures are determined based on geographic market analysis in surrounding jurisdictions. There is no automatic inflation increase. In 2006 direct care worker rates were adjusted to provide a realistic rate in line with neighboring jurisdictions and consistent with DC Council mandate to provide a rate acceptable for direct care workers (a living wage rate).

The rate-setting methodology used for Medicaid services delivered through traditional agency-based model will remain the same for services that are participant-directed. Participants who elect to use PDS will determine hourly rate paid to their participant-directed workers within range set by DHCF, which falls between District's established living wage and the rate paid to PCAs delivering Waiver services through the agency-based model. The Vendor Fiscal/Employer Agent Financial Management Services (VF/EA FMS) - Support Broker entity will assist participants who elect to use PDS through provision of financial management and support broker services, and will receive a PMPM payment for provision of these services. In addition to the PMPM payment, VF/EA FMS-Support Broker entity will receive one-time payment for enrolling participant/representative employer into its employer database and a one-time payment for enrolling each participant-directed worker into its payroll system. Rates for all three (3) types of payment made to VF/EA FMS-Support Broker entity are set through contract negotiation process on annual basis and included in VF/EA FMS-Support Broker entity's contract with DHCF.

The reimbursement methodology and daily rate for Assisted Living services has been updated to reflect reasonable cost of providing services in the District. The daily rate is predicated on the following factors:

- (1) PCA wage, based on the District's Living Wage rate, plus overtime and time off calculations.*
- (2) Skilled nursing care wage.*
- (3) Hours for LPN staffing plus overtime and time off calculations to address medication administration rules of the District.*
- (4) Compensation for RN oversight for medication administration and health assessments per District policy of 1:12 HCBS individuals.*
- (5) Compensation for House Manager for (PCA) supervision per District policy of 1:12 HCBS waiver individuals.*
- (6) A 20% fringe benefit rate applied to employee wages for RNs, LPNs, PCAs, and skilled nursing staff to reflect actual costs in the District.*
- (7) A general and administrative percentage of 13% is applied based on the total costs of all services. This percentage is based on reasonable comparison with other comparable residential care provider categories.*
- (8) A 93% occupancy rate is applied to the rate to account for hospitalization, LTC, and vacation time that is not billable to HCBS waiver program. The 93% factor was used, to promote parity with other residential services that have a vacancy factor.*
- (9) The rate is adjusted annually for inflation, based on increases to the District Living Wage and on Centers for Medicare and Medical Services (CMS) Skilled Nursing Facility Market Basket Index.*

Medicaid reimbursement for Community Transition services shall be limited to a maximum of five thousand dollars (\$5,000) per person for the duration of the EPD Waiver period as a one-time, non-recurring expense.

The reimbursement methodology for case-management services under the EPD Waiver is an all-inclusive monthly (PMPM) capitation rate, updated annually to account for inflation. The capitation rate provides better correlation between reimbursements and the number of beneficiaries receiving case management services. The monthly capitation rate is established based on an analysis of the following: the average industry salary for case managers, administrative cost allowances, and sufficiency of funding for case manager wages. In determining the salary, DHCF relied on the current compensation scale for case managers providing similar services at the District's Department of Disability Services (DDS), which ranges from \$73,489 to \$94,749 including salary and benefits. The caseload of case managers at DDS ranges from 45:1 to 20:1, depending on the intensity of the assigned cases. However, for purposes of EPD waiver population, an estimated caseload of 30:1 will be used, based on the intensity of services required.

Reimbursement for Chore Aide and Homemaker Services under the EPD Waiver Home care services are usually provided by Home Health Agencies, but may also be obtained from independent providers. Personnel are assigned according to needs and wishes of each client. Prior authorization (PA) is required to provide services. DHCF reimbursed Home Health Agency for Chore Aide and Homemaker services under the EPD Waiver. Chore Aides are currently reimbursed an hourly rate of \$15.00 and Homemaker at \$10.48. The current living wage in the District is \$13.80 hourly, and at minimum chore aide and homemaker professionals must be reimbursed at this wage. To attract providers and provide access to services for beneficiaries, DHCF is increasing reimbursement rates for Chore Aide and Homemaker services to reimburse providers at rates that cover necessary employment related taxes, benefits and other administrative overhead costs. The established reimbursement methodology is as follows: The reimbursement rate is calculated using the living wage of \$13.80 as the base, an addition of 30% for employee related taxes, benefits and overhead costs. The rate will be inflated annually beginning with FY 2016, by adjustment to the living wage and inflation based on the Centers for Medicare and Medical Services (CMS) Skilled Nursing Facility Market Basket Index.

Computation-1) Base Rate (Living Wage) = \$13.80 + \$4.14 (30%) 2) FY 2016 Rate – October 1, 2015 \$17.94 x 2.3% (CPI) = \$18.35

EPD waiver ADHP providers shall be reimbursed at the current reimbursement rate for Acuity Level 2, ADHP under the current 1915(i) State Plan reimbursement methodology and rate. The daily rate for a program serving participants with a maximum acuity level with at least one staff member shall be one hundred and twenty five dollars and seventy eight cents (\$125.78) per day.

Effective October 1, 2015 (FY 2016) and thereafter, the uniform per-diem rates, shall be inflated by the Centers for Medicare and Medical Services (CMS) Skilled Nursing Facility Market Basket Index.

DHCF updated reimbursement rates for PCA services based on audit of Home Health Agency (HHA) cost reports. The new rate covers the DC Living Wage increases, employment related taxes, employee benefits and reasonable administrative overhead costs. The rate will be inflated annually, starting in FY 2016, based on adjustments to the Living Wage or the inflation based on the Centers for Medicare and Medical Services (CMS) Skilled Nursing Facility Market Basket Index.

The reimbursement methodology was established based on the following components:

- (1) District's living wage of \$13.80 as established by the DC Department of Employment Services;*
- (2) 10.83% Taxes – Social Security (6.2%), Medicare (1.45%), Workers Compensation (2%) and Unemployment Benefits (1.18%);*
- (3) 7.4% Employee Benefits – Medical Insurance and Sick Leave Provision; and*
- (4) 18% - Provider Indirect Administrative Overhead based on reasonable comparisons with other comparable provider categories.*

The District has established four rates for four different environmental accessibility adaptations with a maximum allowable lifetime cost per recipient of \$10,000. These rates were based upon a geographic market analysis of costs and a review of contractors across the District of Columbia, Maryland and Virginia. Major environmental accessibility adaptations require the assessment of rehabilitation engineer or other professional qualified to make a home accessibility assessment. This assessment includes evaluation of the current home and identifies the most cost-effective and beneficial manner to permit accessibility of the for the waiver recipient. Once the most cost-effective and beneficial accessibility adaptation is identified, and specifications have been developed, bids are obtained to secure the most competitive price. DHCF provides payment based upon the lowest of the submitted price quotes. This reimbursement methodology has been in effect as part of the District's approved waiver since 2007.

The four rates are:

- (a) Unit A: Stair Climber - \$2,000*
- (b) Unit B: Porch Lift - \$3,000*
- (c) Unit C: Bathroom Modifications - \$2,000; and*
- (d) Unit D: Small Ramp - \$90.00 per linear foot.*

Respite care is short-term care provided to individual only when necessary to relieve family members or other persons caring for the individual at home. The reimbursement methodology for (1-17 hours) respite mirrors that of PCA services.

The reimbursement methodology was established based on the following components:

- (1) District's living wage of \$13.80 as established by the DC Department of Employment Services;*
- (2) 10.83% Taxes – Social Security (6.2%), Medicare (1.45%), Workers Compensation (2%) and Unemployment*

Benefits (1.18%);

(3) 7.4% Employee Benefits – Medical Insurance and Sick Leave Provision; and

(4) 18% - Provider Indirect Administrative Overhead based on reasonable comparisons with other comparable provider categories.

Beginning state fiscal year 2023, DHCF will make supplemental payments as described in Appendix I-3-c. These supplemental payments are made in addition to the rates paid for waiver services and are designed to strengthen the direct service workforce and to increase the pay of direct support professionals who are likely to be paid at or near the minimum/living wage.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All fee for service claims including those for waiver services are submitted to the Fiscal Intermediary, currently ACS Government Healthcare Solutions, for processing in the MMIS. Claims can be submitted on paper or electronically via HIPAA compliant transactions. Providers can submit electronic claims via the DHCF web portal, using billing agents or directly through third party software.

Once submitted, claims are processed through the MMIS and run through a large set of edits to ensure proper format and compliance with Federal and District regulations. Edits ensure that beneficiary's are eligible to receive the services rendered, providers are eligible to provide those services and that services were rendered appropriately. Claims that fail an edit can either deny or suspend for further review. Suspended claims are reviewed by ACS claims staff and are set to either pay or deny based on District rules and regulations.

Remittance Advices (RA) are produced and distributed to providers after every payment cycle identifying all claims processed their disposition (Paid/Denied/Suspended) and the total amount due to them. Any claims that do not pay are accompanied with a description of the edit that caused them to either deny or suspend. Those descriptions are used by providers to correct errors and resubmit claims for payment.

The MMIS adjudicates claims on a daily basis and runs payment cycles once a week. Payment cycles result in warrant files that are submitted to the District Treasury. All checks are generated and issued by the Treasury. The Treasury returns a file to the MMIS once checks are issued that identify check numbers and dates. The MMIS updates the payment file to include this information and maintains it as part of the permanent record.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

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Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

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Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.*** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Billing validation consists of both pre- and-post payment processes. Pre-payment validation consists of edits within the MMIS claims processing logic to ensure that three conditions exist prior to paying a waiver claim. The first condition is that the beneficiary must be enrolled in the waiver on the date of service. The system verifies this by checking the beneficiary's program code for the date of service and ensuring the code is associated with the waiver. The second condition is that the provider is eligible to render waiver services to waiver beneficiaries. Providers must obtain waiver provider numbers in order to render waiver services to beneficiaries. The system checks the billing provider number and validates that it is a waiver provider type. The final prepayment validation edits verify that the services were provided in accord with limits and requirements specified in the waiver; such as that prior authorization was given for each waiver service delivered, and that the quantity of waiver services provided does not exceed limits specified in the waiver. If any of these conditions is false, the claim will be denied for payment.

Post payment validation of claims is conducted by the State Agency's Division of Program Integrity - Surveillance and Utilization Branch. Staff from this Branch annually audit claims submitted for waiver services. These audits consist of pulling a random sample of claims and then going on-site to waiver providers' offices to compare information submitted on the claims to patient care documentation. These audits always assess whether or not the service is included in the participant's approved service plan and whether evidence exists that services were provided. In instances in which documentation does not affirm either of these, the state agency recovers the payment made and returns the federal share. Random sampling of such claims is an efficient approach to validation and ensuring appropriate payment recovery because State regulations provide the state agency with the authority to extrapolate the rate of denied claims in the sample to the universe of similar claims from the provider and recover a percent of payment equal to the error rate observed in the sample.

- e. Billing and Claims Record Maintenance Requirement.*** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):***

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

(a) Beginning state fiscal year 2023, DHCF will make supplemental payments to strengthen the direct service workforce and to increase the pay of direct support professionals who are likely to be paid at or near the minimum/living wage for delivering the following waiver services:

- Adult Day Health
- Homemaker
- Personal Care Aide
- Respite
- Assisted Living
- Chore Aide

Supplemental payments will be disbursed to provider agencies in annual, lump sum allotments.

(b) To qualify for a supplemental payment, a provider agency must submit cost and employment data (e.g., a schedule of direct support professionals, their wages paid, hours worked, hire dates, and vacancy rates), at the request of the District, and must demonstrate that supplemental allotments are used (in their entirety) to pay direct support professional staff a benchmark wage rate, set above the District of Columbia's living/minimum wage rate.

(c) District funds equivalent to the federal funds attributable to the increased Federal Medical Assistance Percentage authorized under Section 9817 of the American Rescue Plan Act of 2021 are used for the non-federal share of supplemental payments.

(d) Eligible provider agencies retain 100% of the total computable expenditure claims by the District to CMS. The District may recoup supplemental payments from provider agencies which fail to submit the required cost data or pay direct supports professionals an average wage below the benchmark wage rate. The federal share for any recouped payments is returned through an adjustment to the CMS 64 Report.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

[Empty text box]

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

[Empty text box]

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

[Empty text box]

Appendix I: Financial Accountability

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

EPD waiver services are covered as a part of a comprehensive Medicaid benefit delivered via an integrated Medicare-Medicaid health plan operating as a highly integrated or fully integrated dual eligible special needs plan (HIDE or FIDE SNP). Any such plans offer coverage District-wide. All waiver services and virtually all other Medicaid services are included in the coverage offered by contracted D-SNPs, with the exception of services under the District’s 1915(c) Medicaid waivers serving individuals with intellectual disabilities; services delivered by intermediate care facilities for individuals with intellectual or developmental disabilities (ICF/IID); and community-based behavioral health services delivered by specified mental health and substance use providers. The D-SNPs are paid a monthly Medicaid capitation payment, which reflects the scope of Medicaid services covered by the plans and Medicare cost-sharing associated with enrolled beneficiaries.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as

CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

The reimbursement methodology and rate for Assisted Living services has been updated to better reflect the reasonable cost of providing the service in the District.

The Assisted Living services daily rate is predicated on the following factors:

- (1) PCA wage, based on the District's Living Wage rate, plus overtime and time off calculations.*
- (2) Skilled nursing care wage.*
- (3) Hours for LPN staffing plus overtime and time off calculations to address medication administration rules of the District.*
- (4) Compensation for RN oversight for medication administration and health assessments per District policy of 1:12 HCBS individuals.*
- (5) Compensation for House Manager for (PCA) supervision per District policy of 1:12 HCBS waiver individuals.*
- (6) A 20% fringe benefit rate applied to employee wages for RNs, LPNs, PCAs, and skilled nursing staff to reflect actual costs in the District.*
- (7) A general and administrative percentage of 13% is applied based on the total costs of all services. This percentage is based on reasonable comparison with other comparable residential care provider categories.*
- (8) Lastly a 93% occupancy rate is applied to the rate to account for hospitalization, LTC, and vacation time that is not billable to HCBS waiver program. The 93% factor was used, to promote parity with other residential services that have a vacancy factor.*

The rate is adjusted annually for inflation, based on increases to the District Living Wage and on Centers for Medicare and Medical Services (CMS) Skilled Nursing Facility Market Basket Index.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	40957.86	37366.80	78324.66	94763.71	3539.52	98303.23	19978.57
2	49465.10	25513.57	74978.67	93421.32	3615.79	97037.11	22058.44
3	52958.33	26974.85	79933.18	92112.36	3685.98	95798.34	15865.16
4	56415.19	29593.52	86008.71	90804.96	3762.32	94567.28	8558.57
5	57450.80	31316.97	88767.77	89476.87	3846.90	93323.77	4556.00

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	6060		6060
Year 2	6160		6160
Year 3	6260		6260
Year 4	6360		6360
Year 5	6460		6460

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay was determined by taking the total unduplicated participants divided by the total days of waiver coverage for each prior waiver year. All the past history was then used to project the remaining waiver years using a trend analysis. In completing the trend, the days were restricted to not exceed 365 days in a year. The District is continuing to trend the historic average lengths of stay, but we have revised the historic period on which we have based the trend. The District is now basing the trend on actual average lengths of stay from the second year of the previous waiver (April 2018 - April 2019) through the most recent year for which we have data (April 2020 - April 2021). The forecasted average lengths of stay are shown in the table below.

Year	ALOS
Waiver Year 1	-- 330
Waiver Year 2	-- 332
Waiver Year 3	-- 334
Waiver Year 4	-- 336
Waiver Year 5	-- 338

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D calculates the annual average per-person cost for waiver-specific services for individuals in the EPD waiver program. To project this factor for the waiver renewal period years 1-5, we forecasted both the number of users and the utilization level for each waiver-specific service based on historical trends, while also accounting for any anticipated utilization increases/decreases. We then multiplied these two projections together to get annual anticipated total units. Multiplying this figure by the average cost per unit for each service area led to the total cost, by year, by service area. This summation of the total cost, by year, for all service areas divided by total projected unduplicated participants in the waiver program resulted in the forecasted Factor D for the waiver renewal period years 1-5. The annual growth is based on the Washington, DC Consumer Price Index (CPI) percentage, which is 2.2%. For Environment Accessibility and Adaptation Services assumes 1 user due to minimal use in historical data, each beneficiary may only use this service one time and the average cost per unit is limited to \$10k per person. Each Environment Accessibility and Adaptation projection is priced out individually based on the specific needs of the waiver participant. As a result, the District trends forward based on utilization of the service.

For Community Transition Services, the number of users trended based on historical data, by definition, the average number of units per user is 1, because this service is available one-time to each transitioning beneficiary and the average cost is the limit in the waiver.

PCA assumes growth in utilization due to moving the first 8 hours of PCA into the waiver. As a reasonable proxy for Respite, Individual Directed Goods and Services, and Participant-Directed Community Support Services, they are linked to the weighted growth rates for users of the waiver.

The 500 additional people for WY1 was to account for onboarding of new Assisted Living Facilities, and the additional 100 per year mirrors the current growth rate of the waiver over recent waiver years.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Using the most recent waiver year (April 2020 - April 2021) as the base, we inflated Factor D' at the same rate as the projected growth in Factor D. Factor D' for most services was trended based on actuals from historical data taken from the 372 report and the Washington, DC metro area Consumer Price Index (CPI).

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is projected for the waiver renewal period years 1-5, by forecasting each year by trending off the historical data. Factor G trends Nursing Facility users based on historical actuals taken from the 372 report time period 4/4/20-4/3/21, minus the D-SNP users. The Nursing Facility average cost/unit increase was based on Washington, DC CPI %. For D-SNP we used historical information taken from DHCF contracted actuary and applied the actuary growth rate for the users and average Cost/unit.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is projected for the waiver renewal period years 1-5, by forecasting each waiver year by trending off the rate of change from historical data. Factor G' is not trended but rather based on the rate of change from historical actuals for Nursing Facility users taken from the previous waiver year. The average cost/unit increase was based on CPI %.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Adult Day Health	
Case Management	

Waiver Services	
Homemaker	
Personal Care Aide	
Respite	
Assisted Living	
Chore Aide	
Community Transition Services	
DSNP/Managed Care Capitated Waiver Services	
Environment Accessibility and Adaptation Services	
Individual Directed Goods and Services	
Participant-Directed Community Support Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							367588.00
Adult Day Health	<input type="checkbox"/>	day	10	260.00	141.38	367588.00	
Case Management Total:							13426279.90
Case Management	<input type="checkbox"/>	month	4415	11.00	276.46	13426279.90	
Homemaker Total:							298270.08
Homemaker	<input type="checkbox"/>	hour	123	115.20	21.05	298270.08	
Personal Care Aide Total:							95590881.00
Personal Care Aide	<input type="checkbox"/>	15 minutes	1900	8904.60	5.65	95590881.00	
Respite Total:							70715.40
Respite	<input type="checkbox"/>	15 minutes	28	447.00	5.65	70715.40	
Assisted Living							16508042.46
GRAND TOTAL:							248204619.35
Total: Services included in capitation:							49295715.00
Total: Services not included in capitation:							198908904.35
Total Estimated Unduplicated Participants:							6060
Factor D (Divide total by number of participants):							40957.86
Services included in capitation:							8135.00
Services not included in capitation:							32823.25
Average Length of Stay on the Waiver:							330

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Assisted Living		day	380	245.70	176.81	16508042.46	
Chore Aide Total:							4843.60
Chore Aide		hour	39	5.90	21.05	4843.60	
Community Transition Services Total:							
Community Transition Services		one-time service	36	1.00	5000.00	180000.00	
DSNP/Managed Care Capitated Waiver Services Total:							
DSNP/Managed Care Capitated Waiver Services		month	1645	12.00	2497.25	49295715.00	
Environment Accessibility and Adaptation Services Total:							
Environment Accessibility and Adaptation Services		one-time service	1	1.00	10000.00	10000.00	
Individual Directed Goods and Services Total:							
Individual Directed Goods and Services		item	5	62.70	32.42	10163.67	
Participant-Directed Community Support Services Total:							
Participant-Directed Community Support Services		15 minutes	969	13231.80	5.65	72442120.23	
GRAND TOTAL:							248204619.35
Total: Services included in capitation:							49295715.00
Total: Services not included in capitation:							198908904.35
Total Estimated Unduplicated Participants:							6060
Factor D (Divide total by number of participants):							40957.86
Services included in capitation:							8135.00
Services not included in capitation:							32823.25
Average Length of Stay on the Waiver:							330

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that

service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							375674.00
Adult Day Health		day	10	260.00	144.49	375674.00	
Case Management Total:							11872734.30
Case Management		month	4515	9.00	292.18	11872734.30	
Homemaker Total:							329720.83
Homemaker		hour	133	115.20	21.52	329720.83	
Personal Care Aide Total:							152312661.27
Personal Care Aide		15 minutes	1947	13534.50	5.78	152312661.27	
Respite Total:							76166.53
Respite		15 minutes	29	454.40	5.78	76166.53	
Assisted Living Total:							11302436.99
Assisted Living		day	161	321.20	218.56	11302436.99	
Chore Aide Total:							3271.04
Chore Aide		hour	40	3.80	21.52	3271.04	
Community Transition Services Total:							180000.00
Community Transition Services		one-time service	36	1.00	5000.00	180000.00	
DSNP/Managed Care Capitated Waiver Services Total:							51207140.16
DSNP/Managed Care Capitated Waiver Services		month	1672	12.00	2552.19	51207140.16	
Environment Accessibility and Adaptation Services Total:							10000.00
Environment						10000.00	
GRAND TOTAL:							304705029.29
Total: Services included in capitation:							51207140.16
Total: Services not included in capitation:							253497889.13
Total Estimated Unduplicated Participants:							6160
Factor D (Divide total by number of participants):							49465.10
Services included in capitation:							8312.85
Services not included in capitation:							41152.25
Average Length of Stay on the Waiver:							332

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Accessibility and Adaptation Services		one-time service	1	1.00	10000.00		
Individual Directed Goods and Services Total:							10568.47
Individual Directed Goods and Services		item	5	63.80	33.13	10568.47	
Participant-Directed Community Support Services Total:							77024655.70
Participant-Directed Community Support Services		15 minutes	985	13529.00	5.78	77024655.70	
GRAND TOTAL:							304705029.29
<i>Total: Services included in capitation:</i>							51207140.16
<i>Total: Services not included in capitation:</i>							253497889.13
<i>Total Estimated Unduplicated Participants:</i>							6160
<i>Factor D (Divide total by number of participants):</i>							49465.10
<i>Services included in capitation:</i>							8312.85
<i>Services not included in capitation:</i>							41152.25
<i>Average Length of Stay on the Waiver:</i>							332

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							383942.00
Adult Day Health		day	10	260.00	147.67	383942.00	
Case Management Total:							13478522.85
Case Management		month	4615	9.00	324.51	13478522.85	
GRAND TOTAL:							331519172.43
<i>Total: Services included in capitation:</i>							53178835.92
<i>Total: Services not included in capitation:</i>							278340336.50
<i>Total Estimated Unduplicated Participants:</i>							6260
<i>Factor D (Divide total by number of participants):</i>							52958.33
<i>Services included in capitation:</i>							8495.02
<i>Services not included in capitation:</i>							44463.31
<i>Average Length of Stay on the Waiver:</i>							334

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker Total:							362254.46
Homemaker		hour	143	115.20	21.99	362254.46	
Personal Care Aide Total:							161535987.90
Personal Care Aide		15 minutes	1995	13723.80	5.90	161535987.90	
Respite Total:							81738.60
Respite		15 minutes	30	461.80	5.90	81738.60	
Assisted Living Total:							20639232.77
Assisted Living		day	294	321.20	218.56	20639232.77	
Chore Aide Total:							1532.70
Chore Aide		hour	41	1.70	21.99	1532.70	
Community Transition Services Total:							180000.00
Community Transition Services		one-time service	36	1.00	5000.00	180000.00	
DSNP/Managed Care Capitated Waiver Services Total:							53178835.92
DSNP/Managed Care Capitated Waiver Services		month	1699	12.00	2608.34	53178835.92	
Environment Accessibility and Adaptation Services Total:							10000.00
Environment Accessibility and Adaptation Services		one-time service	1	1.00	10000.00	10000.00	
Individual Directed Goods and Services Total:							10970.64
Individual Directed Goods and Services		item	5	64.80	33.86	10970.64	
Participant-Directed Community Support Services Total:							81656154.58
Participant-						81656154.58	
GRAND TOTAL:							331519172.43
Total: Services included in capitation:							53178835.92
Total: Services not included in capitation:							278340336.50
Total Estimated Unduplicated Participants:							6260
Factor D (Divide total by number of participants):							52958.33
Services included in capitation:							8495.02
Services not included in capitation:							44463.31
Average Length of Stay on the Waiver:							334

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Directed Community Support Services		15 minutes	1001	13826.20	5.90		
GRAND TOTAL:							331519172.43
Total: Services included in capitation:							53178835.92
Total: Services not included in capitation:							278340336.50
Total Estimated Unduplicated Participants:							6260
Factor D (Divide total by number of participants):							52958.33
Services included in capitation:							8495.02
Services not included in capitation:							44463.31
Average Length of Stay on the Waiver:							334

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							392392.00
Adult Day Health		day	10	260.00	150.92	392392.00	
Case Management Total:							14445298.35
Case Management		month	4715	9.00	340.41	14445298.35	
Homemaker Total:							396047.23
Homemaker		hour	153	115.20	22.47	396047.23	
Personal Care Aide Total:							171615397.95
Personal Care Aide		15 minutes	2045	13917.00	6.03	171615397.95	
Respite Total:							87688.86
Respite		15 minutes	31	469.10	6.03	87688.86	
Assisted Living							29835625.60
GRAND TOTAL:							358800621.79
Total: Services included in capitation:							55212392.64
Total: Services not included in capitation:							303588229.15
Total Estimated Unduplicated Participants:							6360
Factor D (Divide total by number of participants):							56415.19
Services included in capitation:							8681.19
Services not included in capitation:							47734.00
Average Length of Stay on the Waiver:							336

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Assisted Living		day	425	321.20	218.56	29835625.60	
Chore Aide Total:							1887.48
Chore Aide		hour	42	2.00	22.47	1887.48	
Community Transition Services Total:							180000.00
Community Transition Services		one-time service	36	1.00	5000.00	180000.00	
DSNP/Managed Care Capitated Waiver Services Total:							55212392.64
DSNP/Managed Care Capitated Waiver Services		month	1726	12.00	2665.72	55212392.64	
Environment Accessibility and Adaptation Services Total:							10000.00
Environment Accessibility and Adaptation Services		one-time service	1	1.00	10000.00	10000.00	
Individual Directed Goods and Services Total:							11386.69
Individual Directed Goods and Services		item	5	65.80	34.61	11386.69	
Participant-Directed Community Support Services Total:							86612504.98
Participant-Directed Community Support Services		15 minutes	1017	14123.50	6.03	86612504.98	
GRAND TOTAL:							358800621.79
Total: Services included in capitation:							55212392.64
Total: Services not included in capitation:							303588229.15
Total Estimated Unduplicated Participants:							6360
Factor D (Divide total by number of participants):							56415.19
Services included in capitation:							8681.19
Services not included in capitation:							47734.00
Average Length of Stay on the Waiver:							336

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that

service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							400634.00
Adult Day Health		day	10	260.00	154.09	400634.00	
Case Management Total:							15474495.15
Case Management		month	4815	9.00	357.09	15474495.15	
Homemaker Total:							430945.92
Homemaker		hour	163	115.20	22.95	430945.92	
Personal Care Aide Total:							182319169.03
Personal Care Aide		15 minutes	2097	14114.10	6.16	182319169.03	
Respite Total:							93927.68
Respite		15 minutes	32	476.50	6.16	93927.68	
Assisted Living Total:							23159928.96
Assisted Living		day	348	304.50	218.56	23159928.96	
Chore Aide Total:							1973.70
Chore Aide		hour	43	2.00	22.95	1973.70	
Community Transition Services Total:							180000.00
Community Transition Services		one-time service	36	1.00	5000.00	180000.00	
DSNP/Managed Care Capitated Waiver Services Total:							57286341.60
DSNP/Managed Care Capitated Waiver Services		month	1754	12.00	2721.70	57286341.60	
Environment Accessibility and Adaptation Services Total:							10000.00
Environment						10000.00	
GRAND TOTAL:							371132185.82
Total: Services included in capitation:							57286341.60
Total: Services not included in capitation:							313845844.22
Total Estimated Unduplicated Participants:							6460
Factor D (Divide total by number of participants):							57450.80
Services included in capitation:							8867.85
Services not included in capitation:							48582.95
Average Length of Stay on the Waiver:							338

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Accessibility and Adaptation Services		one-time service	1	1.00	10000.00		
Individual Directed Goods and Services Total:							11817.89
Individual Directed Goods and Services		item	5	66.90	35.33	11817.88	
Participant-Directed Community Support Services Total:							91762951.90
Participant-Directed Community Support Services		15 minutes	1033	14420.70	6.16	91762951.90	
GRAND TOTAL:							371132185.82
<i>Total: Services included in capitation:</i>							57286341.60
<i>Total: Services not included in capitation:</i>							313845844.22
Total Estimated Unduplicated Participants:							6460
<i>Factor D (Divide total by number of participants):</i>							57450.80
<i>Services included in capitation:</i>							8867.85
<i>Services not included in capitation:</i>							48582.95
Average Length of Stay on the Waiver:							338