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

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

Request for 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:
People with Intellectual and Developmental Disabilities (IDD) Waiver - 2026 Amendment

C. Waiver Number:DC.0307
Original Base Waiver Number: DC.0307.90R1

D. Amendment Number:DC.0307.R05.03

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

08/01/26

Approved Effective Date: 08/01/26
Approved Effective Date of Waiver being Amended: 10/01/22

2. Purpose(s) of Amendment

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

The purpose of this amendment is to do the following:

- Remove monetary cap for creative arts therapies.
- Modify Assistive Technology services.
- Modify Companion Services by adding an one-to-two (1:2) staffing to person ratio for persons residing in Supported Living and Residential Habilitation residential settings.
- Clarify staffing ratio for day habilitation services and employment readiness services.
- Modify In-Home Supports services criteria for support hours of forty (40) to fifty-six (56) per week.
- Remove Personal Emergency Response System (PERS) as a standalone service.
- Clarification to QIDP/QDDP qualifications and requirement of a human services degree and continuing education courses.
- Remove the requirement for Direct Support Professionals (DSPs) to provide proof of COVID vaccination per DC Health Requirements.
- Add Licensed Professional Art Therapist (LPAT) credential to the behavioral support services and art therapy services as an independent clinician for paraprofessional services.
- Add qualifications, training, or competency requirements for HCBS settings criteria and person-centered plan development for Service Service Coordinators.
- Add the following two (2) new waiver services: (1) Health Assessment and Coordination; and (2) State Option to Provide HCBS in Acute Care Hospitals.
- Add the DC living wage adjustment rate for DSPs.
- Removal of the following performance measures: (1) Number of non-licensed/non-certified providers that adhered to waiver requirements; (2) Percentage of Mortality Review Committee (MRC) death investigations completed; (3) Percent of claims for IDD waiver services denied by MMIS; and (4) Percentage of provider payment rates that are consistent with rate methodology approved in the approved waiver application.
- Supported Living service definition modification to specify current utilization of supported living staffing only service.
- Activate the waitlist for IDD services.

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**	
☐ **Appendix A - Waiver Administration and Operation**	
☐ **Appendix B - Participant Access and Eligibility**	
☑ **Appendix C - Participant Services**	
☐ **Appendix D - Participant Centered Service Planning and Delivery**	
☐ **Appendix E - Participant**	

Component of the Approved Waiver	Subsection(s)
Direction of Services	
☐ Appendix F - Participant Rights	
☐ Appendix G - Participant Safeguards	
☐ Appendix H	
☑ Appendix I - Financial Accountability	
☑ Appendix J - Cost-Neutrality Demonstration	

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:

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 section 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*):

People with Intellectual and Developmental Disabilities (IDD) Waiver - 2026 Amendment

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.0307
Waiver Number:DC.0307.R05.03
Draft ID: DC.002.05.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/22
Approved Effective Date of Waiver being Amended: 10/01/22

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: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 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:

○ **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:

D.C. Official Code § 7-761.03(7A) and 7-1301.04(15A), and as amended by the Developmental Disability Eligibility Reform Amendment Act of 2022, means a person that is diagnosed before 22 years of age with an intellectual disability as set forth in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. In addition, eligibility for services is expanded to people with a developmental disability as defined in D.C. Official Code §§ 7-761.02(3A) and 7-1301.03(8D), and as amended by the Developmental Disability Eligibility Reform Amendment Act of 2022, means a severe and chronic disability of a person that is attributable to a mental or physical impairment, other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments; is manifested before 22 years of age; is likely to continue indefinitely; results in substantial functional limitations in 3 or more of the following areas of major life activity: self-care; understanding and use of language; functional academics; social skills; mobility; self-direction; capacity for independent living; or health and safety; and reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are person-centered, planned, and coordinated.

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 section 1915(a)(1)(a) of the Act and described in Appendix I**
- ☐ **Waiver(s) authorized under section 1915(b) of the Act.**

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

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

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

- ☐ **A program operated under section 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 section 1915(i) of the Act.**
- ☐ **A program authorized under section 1915(j) of the Act.**
- ☐ **A program authorized under section 1115 of the Act.**

Specify the program:

H. Dual Eligiblity 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 DC HCBS IDD Waiver program provides persons enrolled in Medicaid with intellectual and/or developmental disabilities the opportunity to receive a range of habilitative and health care services and supports, based upon their level of need, that are not available under the District of Columbia Medicaid State Plan.

Goals: The waiver aims to enable participants to: (1) lead healthy, independent, and productive lives; (2) live, work, and fully participate in their communities to the fullest extent possible; (3) fully exercise their rights as District of Columbia residents; and (4) promote the integrity and well-being of their families. Further, the HCBS IDD waiver is intended to meet each person's needs, goals, and preferences in the most integrated, least restrictive setting possible; and provide services that are: safe, effective, person-centered, timely, efficient, and equitable.

Objectives: The objectives of this waiver are to ensure that: (1) There are sufficient alternatives and supports that will enable people to live with the least amount of paid support while promoting independence for participants through the provision of services meeting the highest standards of quality and national best practices; (2) All people have an opportunity to acquire essential skills and receive the supports necessary to enter the workforce and pursue careers of their choosing; (3) All people have access to the necessary services and supports that will enable aging in the least restrictive setting possible; (4) The full range of health and clinical services necessary to help persons with complex support needs choose an alternative to institutional services, if desired and feasible, are available; (5) Provision of person-centered services while ensuring health and safety through a comprehensive system of participant safeguards; (6) Alternatives to institutionalization and costly comprehensive services are available through the provision of an array of services and supports that promote community inclusion and independence by enhancing and not replacing existing informal networks; and (7) Participants and their families are supported in exercising their rights and share responsibility for their programs.

Organizational Structure: The DC Department of Health Care Finance (DHCF) is the Single State Medicaid Agency (SSMA) of the District of Columbia. DHCF's responsibilities include the administration of the Medicaid program and this waiver. This authority can be found at D.C. Official Code §1-307.02 et seq. as authorized by Titles XIX and XXI of the Social Security Act. The Department on Disability Services (DDS), Developmental Disabilities Administration (DDA), is the operating agency for all services provided to persons with intellectual and/or developmental disabilities (IDD). The two agencies have a Memorandum of Understanding (MOU) to assure coordination, cooperation, and collaboration between DHCF and DDS in performing their respective duties in the provision of HCBS IDD Waiver services.

Service Delivery Methods: The HCBS IDD waiver uses traditional service delivery methods. DDA provides each waiver participant with service coordination, as an administrative function. This includes Level of Care determination, development of the Individual Support Plan (ISP), support to access all necessary services and supports, crisis intervention support, and monitoring of the delivery of services and supports. DDA does an assessment of intensity of support needs and urgent needs to access out-of-home residential services through administration of the DC Level of Need Assessment Risk Screening Tool and adherence to DDS waiting list policy and procedures, if applicable. All direct waiver services are delivered by private agencies enrolled as DC Medicaid providers with the DC Medicaid program, operated by DHCF. DDS/DDA approves service authorizations (SAs) following the completion of an ISP, submits the SA to DHCF for Medicaid Prior Authorization, coordinates the selection of service providers with waiver participants, conducts provider network quality assurance and improvement activities, and implements the Incident Management System and Human Rights System to ensure participant safeguards. In addition to its administrative oversight authority, DHCF operates and maintains the Financial Management components of this waiver program.

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 section 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 section 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. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in section 1902(a)(1) of the Act *(select one)*:

- ● **No**
- ○ **Yes**

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

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

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the

following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

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 section 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 in-patients 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 section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 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. 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 Part 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:

PUBLIC NOTICE PROCESS

The District took the following actions to support public notice and awareness of the proposed amendment to 1915(c) Home and Community-Based Services (HCBS) Waiver for People with Intellectual and Developmental Disabilities (IDD).

DDS published an abbreviated notice of amendment to the IDD waiver in the August 15, 2025, issue of the District of Columbia Register (DCR) at Volume 72/33. The abbreviated notice can be found online at https://dcregs.dc.gov/Common/NoticeDetail.aspx?NoticeId=N142033. The abbreviated notice provided interested stakeholders with the date, time, and participation instructions of a virtual public hearing; informed stakeholders on how to submit public comments; and linked directly to the DDS website containing full notice.

On August 15, 2025, DDS published full notice on the DDS website at https://dds.dc.gov/page/hcbs-idd-waiver-2025-amendment. The full draft of the proposed IDD waiver amendment, a summary of proposed changes, and information on how interested stakeholders could give feedback on the proposed IDD waiver amendment was available in the published notice. Hard copies of the notice were also available at the DHCF main office's front desk and from DDS upon request.

The public comment period was open from August 15, 2025, through September 15, 2025, allowing for thirty (30) days of public comment on the proposed amendment. Written comments were accepted by mail, email, and orally during the public hearing. DHCF also preserved comments submitted via the chat function during the public hearing.

During the public comment period, DHCF presented on the proposed IDD waiver amendment application and offered the opportunity for public input at the public hearing on August 22, 2025, from 12:00 to 1:30 p.m., via teleconference and web-conference.

PUBLIC COMMENTS AND THE DISTRICT'S RESPONSES FOR THE FIRST COMMENT PERIOD:

Sandy Bernstein of University Legal Services (ULS): Can you please explain why you are making these changes? Information was provided of the changes but not why these are changes are being made.

DDS Response: DDS is clarifying staffing to person ratios in the waiver, specifically for employment readiness and day habilitation as the current language states a maximum ratio. The in-home supports ratio of 1:6 is specifically for remote supports to align with the staffing to ratio for all waiver remote supports services. The companion service 1:2 ratio will be added in the IDD waiver as it was formerly a flexibility in Appendix K during the public health emergency and will be helpful to people residing in waiver residential settings, specifically supported living and residential habilitation, for supports needed in the home during the day. Telehealth services are added as a subcategory under remote supports services as the criteria of what constitutes as remote supports is different from telehealth. DDS is also relaxing the requirements that are necessary for remote supports services that are not applicable to waiver services that are provided as telehealth services.

Robin Shaffert of Georgetown University Center for Excellence in Developmental Disabilities: Are people living in natural homes eligible for the telehealth triage services? The slide said people could receive the service in their own home but didn't seem to include people living in the natural homes.

DDS Response: No, the Health Assessment and Coordination telehealth service is for people who reside in supported living, residential habilitation, and host home residential settings in the IDD waiver.

Adraine L. Gooden: When is the proposed changes for DSP vaccination?

DDS Response: Proposed changes to the IDD waiver amendment application will be effective January 1, 2026, however, the regulation has already occurred, and the District is aligning the waiver application with the regulation.

Sandy Bernstein of University Legal Services (ULS): So, if someone lives with family but is not in the lease or title of a house, can they not get supported living services?

DDS Response: DDS currently offers supporting living staffing only services to people living in the natural home setting who live alone, per the Supported Living regulations. This is not a change, however, it is being specified in the waiver

application to align with the regulations in Chapter 19 of Title 29 of the DCMR in Section 1943.7(a)-(b).

Ian Paregol - DC Coalition of Disability Service Providers: Since this was really a summary of the proposed changes, can DDS post a link with the actual details of the submission so public comment can be comprehensive?

DDS Response: To review proposed changes to the IDD waiver amendment, please visit the following website: https://dds.dc.gov/page/hcbs-idd-waiver-2025-amendment or https://dds.dc.gov/node/1787961. The presentation will be posted to this website as well. The thirty (30) calendar day public comment period, beginning August 15, 2025, and ending September 15, 2025. The public comment/input period will end on September 15, 2025, at 12:00 p.m.

Adraine L. Gooden: Can a QDDP qualify with a bachelor's degree in a non-human services field, provided they also hold a certification from a nationally accredited body with a focus on supporting individuals with intellectual and developmental disabilities (IDD)?

DDS Response: DDS will consider those who do not have a degree in human services and must have at least continuing education units (CEUs) or a minor in human services in order to be QIDP qualified. DDS will provide information as to which CEUs and minors that will constitute as meeting

CONTINUED AT "B. OPTIONAL"

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: Ebeigbe

First Name: Benjamin

Title: Director, Administration of Long-Term Care

Agency: Department of Health Care Finance

Address: 441 4th Street, NW

Address 2: Suite 900South

City: Washington

State: **Dist. of Columbia**

Zip: 20001

Phone: (202) 724-7085 **Ext:** ☐ **TTY**

Fax: (202) 442-5899

E-mail: benjamin.ebeigbe@dc.gov

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

Last Name: Woodland

First Name: Winslow

Title: Deputy Director, Developmental Disabilities Administration

Agency: Department on Disability Services

Address: One Independence Square

Address 2: 250 E Street, S.W., Fifth Floor

City: Washington, DC

State: **Dist. of Columbia**

Zip: 20024

Phone: (202) 730-1618 **Ext:** ☐ **TTY**

Fax: (202) 730-1842

E-mail: Winslow.Woodland@dc.gov

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 section 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: Mario Ramsey

State Medicaid Director or Designee

Submission Date: Jul 6, 2026

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

Last Name: Byrd

First Name: Melisa

Title: Medicaid Director

Agency: Department of Healthcare Finance

Address: 441 4th Street, NW, 900 South

Address 2:

City: Washington

State: **Dist. of Columbia**

Zip: 20001

Phone: (202) 442-9075 **Ext:** ☐ **TTY**

Fax: (202) 442-9075

E-mail: shanetha.sices2@dc.gov

Attachments

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:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

On October 24, 2025, DDS published additional full notice on the DDS website at https://dds.dc.gov/page/hcbs-idd-waiver-2025-amendment. The updated draft of the proposed Appendix J and information on how interested stakeholders could give feedback on the proposed Appendix J was available in the published notice. Additionally, the updated notice informed stakeholders that the District will activate its waitlist for IDD services, effective January 1, 2026. Hard copies of the notice were available at the DHCF Main Office and from DDS upon request.

The District's thirty (30) day public comment period was open from October 24, 2025, through November 24, 2025, allowing for thirty (30) days of public comment on the proposed amendment to the Appendix J and waitlist. Written comments were accepted by mail and email.

DDS offered the opportunity for public input at the public hearing on October 24, 2025, from 12:00 to 1:30 p.m., via teleconference and web-conference. The below questions are answers were presented at the hearing:

When does the waiting list take effect?

District Response: At this time, the plan is for it to take effect January 1, 2026.

Will this be a permanent implementation?

District Response: The waiting list is in effect fiscal year 2026 and is based on our fiscal year 2026 budget. D.C. Council's perspective regarding the waiting list is that DDA would not have to implement a waiting list until we realize that we don't have enough funds to continue serving people. Which means if within the year, we realize we don't have the funds then we can implement the waiting list at that point. Our concern about implementing a waiting list this way is that we can't start to provide services for people when we don't have confirmation that we have the funds available to serve them, which is against the law in the District. The fact that OCFO has told us that there aren't adequate funds, we have to start our year by developing a budget that provides services consistent with what OCFO says we have budget for, which means there must be a waiting list. The Council's view is that DDA has enough resources, and if we get to six months into the year and we have additional funds then we'll start moving people off of the waiting list. To the extent resources are available, the waiting list will be reduced and eliminated.

So, will people who are awaiting services as of 2025 be automatically placed on the waiting list for 2026?

District Response: If a person is not yet in the waiver on January 1, 2026, and they require services through the IDD Waiver, then they would be placed on the waiting list.

Do students who are aging out of the school system have funds set aside similar to Maryland Transitioning Youth Initiative? Or only students aging out of CFSA have funds set aside?

District Response: Only youth aging out of CFSA at the age of 21 as they are committed to the District of Columbia and waiver slots are reserved for this population. Youth aging out of the school system can access services through the IFS Waiver.

Is there a timeline for how long a person on the waiting list will remain on the waiting list?

District Response: No, it depends on the person's priority determination level (priority, urgent, emergency, or non-urgent) and how many people are on the waiting list. People would be admitted from the waiting list into the IDD Waiver based on their needs and the availability of resources. A person with fewer needs could be on the waiting list for a long time, while a person with significant needs may not be, depending on when resources are available.

Just seeking clarification, if we have an application in now and it is not approved by January 1, they will be automatically placed on the waiting list?

District Response: The application is for DDA services, and if the person is found eligible, they will be assigned a Service Coordinator and will have an Individual Support Plan (ISP). There would be a limitation if there is a waiting list in place to the extent the person needs services that are only available in the IDD Waiver, then they will be placed on the waiting list. Otherwise, the team will try to help them identify resources to meet other needs including the IFS Waiver.

On October 24, 2025, the District received one written comment and the commenters believe that a waiting list is not warranted because there are "open slots" in the waiver program. Additionally, the commenters stated that a waiting list should not be initiated until all slots for the waiver program are filled. Moreover, the commenters stated that while the impending waitlist was

discussed at the Community and Provider Forum, comments were not solicited on people's opinions on the waiting list, and no information was given on how the waiting list would be implemented.

Response: Language establishing the right to implement a waiting list has existed in the Home and Community-Based Services (HCBS) waiver for People with Intellectual and Developmental Disabilities (IDD) since November 20, 2012. General language on how a waiting list would be implemented, including how applicants would be prioritized and removed from the waiting list has also existed in the waiver since 2012. Additionally, this language exists in District regulations and policy. The public notice that the District posted in the D.C. Register and on the IDD waiver website, announced the implementation of a waiting list. Moreover, DDS held a planning meeting on October 10, 2025, where the agency announced the implementation of the IDD Waiver waiting list and informed meeting participants that additional details would be discussed at the next Provider and Community Forum meeting. At least one of the commenters was present at the planning meeting as evidenced by the meeting minutes.

The details of the implementation of the IDD Waiver waiting list were discussed at the October 24, 2025, Provider and Community Forum. DDS also announced the plan for discussion of the waiting list implementation through DDS email subscriptions that were sent to stakeholders and providers in advance of the October 24th Forum. Participants of the public forum were able to provide comments and ask questions during the forum. As explained at the forum, DDS is implementing the waiting list for the IDD waiver as the fiscal year (FY) 2026 budget approved local funds budget included a reduction of $1,681,161.00 in the Operation Services division as a result of cost savings specifically for the HCBS IDD waiver.

To minimize disruption in services to waiver beneficiaries, we have developed a budget plan that provides services consistent with fiscal year budget reductions. DDS is proactively implementing the waiting list to ensure we can provide waiver services to those who have or will start services, as permitted by D.C. law. If DDS's budget allocation changes, the agency will start to move people from the waiting list. To the extent resources are available, the waiting list will be reduced and eliminated.

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:

   (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:

   Department on Disability Services, Developmental Disabilities Administration (DDS/DDA)

   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:

The DC Department of Health Care Finance (DHCF) is the Single State Medicaid Agency (SSMA) of the District of Columbia. DHCF's responsibilities include the administration of the Medicaid program and this waiver. This authority can be found at D.C. Official Code §1-307.02 et seq. as authorized by Titles XIX and XXI of the Social Security Act. The Department on Disability Services (DDS) is the operating agency for all services provided to persons with intellectual and developmental disabilities (IDD). The two agencies have a Memorandum of Agreement (MOA) to assure coordination, cooperation, and collaboration in performing their respective duties in the implementation of this waiver.
DHCF delegates day to day operational authority of the IDD Waiver to DDS. This delegation includes DDS meeting the following four assurances and sub assurances: Level of Care, Service Plans, Qualified Provider, and Health and Welfare. This delegation is further detailed in the IDD Waiver MOA. DHCF, in its Administrative Authority role, retains ultimate authority and oversight for the IDD Waiver and accepts complete responsibility for the entire IDD Waiver including the aforementioned as well as Administrative Authority and Financial Accountability assurances.

In its oversight role, DHCF reviews reports developed by DDS that demonstrate how DDS performs its day-to-day operations. On a quarterly basis, DDS will submit to DHCF reports that document how DDS meets each of its delegated assurance and sub-assurance areas. DHCF will review these reports and assess whether reports demonstrate that the District meets all IDD Waiver assurances identified above. DHCF also conducts audits and surveys of randomly selected services that may include representative sampling of specific providers. In addition, DHCF participates in DDS committees as requested or warranted to monitor processes and service delivery.
In addition, DHCF hosts a quarterly DHCF-DDS/DDA Quality Committee designed just for the Waiver services. The DHCF-DDS/DDA QMC is concerned with the overall operation of the waiver and works to ensure quality and performance measures are being met.
In addition, there is a DDS/DDA Quality Committee responsible for advising DHCF on the challenges that IDD waiver participants face (including their satisfaction with the waiver services being provided) and seeks to find solutions to improve service delivery.

Furthermore, the committee ensures that there is continued communication among all stakeholders. The committee meets monthly and holds regular meetings with stakeholders to review the information received, develop and implement strategies, respond to requests, and report back at subsequent DHCF-DDS/DDA quarterly meetings that involve stakeholders. The QMC had some difficulty in getting IDD waiver participants' involvement and therefore DDS began holding community forums as an alternative method of getting participant feedback regarding satisfaction with the waiver and suggestions for new services.

The MOA defines the cooperative agreement between the agencies in several areas of responsibility and is renewed annually. This MOA is available for CMS review upon request.

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.:*

Two contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and the operating agency.

First, the District of Columbia Medicaid program contracts with a CMS-designated QIO to perform a variety of surveillance and utilization control functions. As a part of this contract, the QIO performs a data entry function whereby it assigns prior authorization numbers to waiver services authorized by the Operating Agency (DDS/DDA). The QIO enters these prior authorization numbers into DC Medicaid's MMIS to allow payment for waiver services. This is part of the District's financial control mechanisms.

Second, the DC Medicaid program contracts with a fiscal agent to administer its claims processing. A subcontractor to the District's fiscal agent has developed a template for expenditures summary report and has generated 372 reports. In addition, this subcontractor works with staff responsible for managing the waiver to ensure accuracy of financial reporting and detecting and remedying any errors in claims processing.

○ **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:

The DC Department of Health Care Finance (DHCF), the designated Medicaid state agency for the District of Columbia, is responsible for assessing the performance of the two contracted entities identified above. Within DHCF, the Health Care Delivery Management Administration's Division of Clinician, Pharmacy, and Acute Provider Services is responsible for assessing the performance of the QIO contractor. Furthermore, DHCF's Health Care Operations Administration, is responsible for assessing the performance of the fiscal agent and its subcontractor.

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:

The contracting officers for the QIO contractor and fiscal agent assess contractor performance on regularly scheduled and ad hoc bases. The Contract Administrator (CA)reviews the report from QIO for accuracy and provide feedback to the contractor on a monthly basis. The CA for the fiscal agent as a part of the on-going assessment of the performance of the contract, holds weekly meetings with the vendor. The purpose of this meeting is to address any known issues affecting adjudication of claims. The meeting is also used to track projects related to the Medicaid Management Information System.

All waiver related services require prior authorization and the system is configured to deny claims for service if the claim is submitted without an authorization, if the dates of service fall outside of the dates on the prior authorization, if the services on the prior authorization do not match the services on the claim, if the units or dollar amount authorized have been exceeded, or if there is a mismatch between the beneficiary/provider on the claim and the prior authorization.

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.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☑	☑	☐
Waiver enrollment managed against approved limits	☑	☑	☐
Waiver expenditures managed against approved levels	☑	☑	☐
Level of care waiver eligibility evaluation	☑	☑	☐
Review of Participant service plans	☑	☑	☐
Prior authorization of waiver services	☑	☑	☑

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
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 state's quality improvement strategy, provide information in the following fields to detail the state's 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:
AA.a.1.a.PM.3. Percentage of settings that meet HCBS settings requirements. Number of settings that meet the HCBS settings requirements (Numerator) / Number of settings reviewed (Denominator).

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 =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
AA.a.1.a.PM.2. Percentage of issues in MCIS resolution system or its replacement system remediated according to DDS' issue resolution policies and procedures. Number of issues remediated within IRC assigned timeframe (numerator)/Number of issues accepted by DDS in the previous quarter (denominator).

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: The frequency for the State Medicaid Agency is on a quarterly basis.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA.a.1.a.PM.1. Percentage of providers that met oversight compliance. Number of providers that met oversight compliance (Numerator)/ Number of providers reviewed (Denominator)

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 =

		Confidence Level 95 & Desired Precision Range 10 Confidence Level 90 and Desired Precision Range 10 Confidence Level 90 & Desired Precision Range 15 Confidence Level 90 & Desired Precision Range 20
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Bi-annual	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☑ **Other** Specify: Bi-annual

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.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Remediating and fixing individual/systemic problems are the shared responsibility of the State Agency's Long Term Care Administration and Health Care Delivery Management Administration, Division of Quality and Health Outcomes, and DDS/DDA. When an issue is identified to represent individual or systemic problems (i.e. data from audits and monitoring visits, etc.) a systemic approach is employed. Remediation activity occurs primarily through the performance of formal discovery activities as discovery/remediation tool which is shared with DDS. This tool includes a description of the issue identified, specific timelines for needed remediation to address any issues identified.

Additionally, DHCF and DDS hold regular teleconference calls and monthly quality management committee meetings to address individual and systemic problems. DDS is required to submit status of remedial action until they are fully addressed and DHCF will follow up on the implementation through random visits.

DHCF staff assigned to monitor compliance with the level of care (LOC) assurance will complete a 100% review based on information from the MCIS/applicable DDS electronic information system intake database for the people seeking waiver services on a quarterly basis. DHCF will aggregate and analyze data quarterly.

As part of the discovery process, DHCF will use their Level of Care Assurance Tool to document all instances and findings where it is determined that LOC criteria was not met and/or participant did not receive re-evaluation as required.

Following implementation of its discovery process, problems and issues identified by DHCF will be shared with DDS, along with recommendations for remediation and improvement within specified timelines.

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**
☑ **Operating Agency**	☑ **Monthly**
☑ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☑ **Other** Specify: For state Medicaid Agency, frequency of data collection is quarterly.

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.

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 Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☑ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☑	**Developmental Disability**	18		☑
	☑	**Intellectual Disability**	18		☑
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

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:

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:

Appendix B: Participant Access and Eligibility

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

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

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	1943
Year 2	1963
Year 3	1983
Year 4	2003
Year 5	2023

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	
Year 2	
Year 3	
Year 4	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 5	

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	
Transition from CFSA to DDS	
Transition from ICF/IDD	

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):*

Transition from CFSA to DDS

Purpose *(describe):*

The District will reserve up to 10 slots per year for each year of the waiver for young adults who are wards of the District and are transitioning from the Child and Family Services Agency (CFSA) to adult services in DDS/DDA. It should be noted that while a maximum number of slots has been specified, actual data from CFSA will be used to determine what needs to be reserved each year.

Describe how the amount of reserved capacity was determined:

Reserve capacity reflects the goal of the District of Columbia to reduce reliance on the use of ICF/DD settings and to increase the use of smaller, integrated residential settings. The number was derived based on DDS experience with and knowledge of the service system. Additionally, the District of Columbia has a commitment to wards of the State that are placed in out-of-home services to assure a seamless transfer to adult services.

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

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

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):*

Transition from ICF/IDD

Purpose *(describe):*

The District will reserve up to 3 slots per year for each year of the waiver to transition people who seek to move from ICF/IDD settings to HCBS waiver services.

Describe how the amount of reserved capacity was determined:

Reserve capacity for transitions from ICF/IDD to HCBS Services is projected based upon tracking and trending actual transitions over the past 10 years.

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

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

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:

Waiver eligibility criteria are:
1) a District of Columbia resident currently receiving services from DDS/DDA;
2) a Medicaid recipient with income up to 300% of SSI; and
3) a Medicaid recipient who meets an ICF/IDD level of care criteria.

Additionally, DDS/DDA will prioritize entrance into the waiver in the following manner: priority for available waiver slots are restricted to any person who has no family or other natural support system to meet his/her assessed need for twenty-four (24) hour residential support; and, any person found to be a Ward of the District of Columbia who has aged out of the DC Child and Family Services Agency (CFSA) who has been in an out-of-home placement and for whom returning to a parental/natural home is not an option.

Persons in emergency situations who meet the criteria for enrollment are then considered for enrollment. Emergency is defined by DDS as an person that has an Emergency Need for enrollment in the DDA HCBS waiver because the health, safety, or welfare of the person or others is in imminent danger and the situation cannot be resolved absent the provision of such services available from the waiver program. Criteria include: clear evidence of abuse, neglect, or exploitation; the death of the person's primary caregiver and lack of alternative primary caregiver; the person is homeless, which is defined as living in a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings; or a shelter, including a severe weather shelter, a low barrier shelter, or a temporary shelter.

An eligible person determined to have an Emergency Need for waiver services will be assigned priority for receiving such services over those determined to have an urgent or non-urgent need. An eligible person is considered to have an urgent need for enrollment in the IDD HCBS waiver if he or she is determined to be at significant risk of having their basic human needs go unmet. An eligible person determined to have a non-urgent need for waiver services will be assigned priority for receiving such services based on whether all other emergency and urgent prioritized needs have been met, whether there is available enrollment space in the waiver, and the availability of local resources.

Each eligible person placed on the waiting list for waiver services will be reviewed based on the date of a completed application and a uniformed set of priority of needs criteria, identified as having an Emergency, Urgent or Non-Urgent need for HCBS IDD waiver services, and will receive services based on these priority rankings. Based on the waiver requirements and the availability of resources, eligible persons on the waiting list will be removed from the waiting list and will begin to receive waiver services in the following priority order:

1. An eligible person determined to have an Emergency need for HCBS IDD waiver services will receive services before all others;

2. An eligible person determined to have an Urgent need for HCBS IDD waiver services will qualify to receive services once all identified emergency needs have been met; there is an available enrollment slot in the waiver; and, sufficient resources are available; and,

3. An eligible person determined to have a Non-urgent need for HCBS IDD waiver services will qualify to receive services when all other prioritized needs have been met; there is an available enrollment slot in the waiver; and, sufficient resources are available. DDS will attach links to the current regulations, policies and procedures.

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)*:

- (●) **Section 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)

- [ ] **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- [ ] **Pregnant Women (42 CFR § 435.116)**
- [ ] **Infants and Children under Age 19 (42 CFR § 435.118)**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**
- [x] **Optional state supplement recipients**
- [x] **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 section 1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 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 section 1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR § 435.330)**
- [x] **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, 2027 (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 section 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 section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 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 period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

○ **Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 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 period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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 period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

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 period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 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 section 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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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 section 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 section 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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 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 or 42 CFR § 435.735:

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: 1

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:

A minimum frequency of service delivery every six months is required.

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 an entity under contract with the Medicaid agency.**

Specify the entity:

- ○ **Other**

Specify:

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

The Qualified Intellectual Disabilities Professional (QIDP) or Qualified Developmental Disabilities Professional (QDDP), is someone who oversees the initial habilitative assessment of a person; develops, monitors, and reviews ISPs; and integrates and coordinates Waiver services.

The QIDP or QDDP shall have at least one (1) of the following qualifications:

i. A psychologist with at least a master's degree from an accredited program and with specialized training or one (1) year of experience in intellectual disabilities or other developmental disabilities;

ii. A physician licensed to practice medicine in the District and with specialized training in intellectual disabilities or with one (1) year of experience in treating persons with intellectual disabilities or other developmental disabilities;

iii. An educator with a degree in education from an accredited program and with specialized training or one (1) year of experience in working with persons with intellectual disabilities or other developmental disabilities;

iv. A social worker with a master's degree from an accredited school of social work and with specialized training in intellectual disabilities or with one (1) year of experience in working with persons with intellectual disabilities or other developmental disabilities;

v. A rehabilitation counselor who is certified by the Commission on Rehabilitation Counselor Certification and who has specialized training in intellectual disabilities or one (1) year of experience in working with persons with intellectual disabilities or other developmental disabilities;

vi. A therapeutic recreation specialist who is a graduate of an accredited program and who has specialized training or one (1) year of experience in working with persons with intellectual disabilities or other developmental disabilities;

vii. A human service professional with at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology) and who has specialized training in intellectual disabilities or one (1) year of experience in working with persons with intellectual disabilities or other developmental disabilities;

viii. A bachelor's degree in any field with a minor in human services, or an equivalent combination of education and continuing education courses in human services, as approved by an accredited institution or board and who has specialized training in intellectual disabilities or one (1) year of experience in working with persons with intellectual disabilities or other developmental disabilities; or

A registered nurse with specialized training in intellectual disabilities or with one (1) year of experience in working with persons with intellectual disabilities or other developmental disabilities.

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 person shall meet the LOC determination if:

Per Title 29 DCMR, Section 1902.4, an individual meets the level of care determination if one of the following criteria has been met, taking into consideration the standard error of measurement for the IQ test:

a. The person's primary disability is an intellectual disability with an intelligence quotient (IQ) of 59 of less; or

b. The person's primary disability is an intellectual disability with an intelligence quotient (IQ) of 60-70, and the person has at least one of the following conditions:
(1) Mobility deficits;
(2) Sensory deficits;
(3) Chronic health needs;
(4) Behavioral challenges;
(5) Autism;
(6) Cerebral Palsy;
(7) Epilepsy; or
(8) Spina Bifida.

c. The person's primary disability is an intellectual disability with an IQ of 60-70, or the person has a developmental disability, either of which results in substantial functional limitations in at least three (3) of the following major life activities:
(1) Self-Care;
(2) Understanding and use of language;
(3) Functional academics;
(4) Social skills;
(5) Mobility;
(6) Self-direction;
(7) Capacity for independent living; or
(8) Health and safety.

Developmental Disability as defined in D.C. Official Code §§ 7-761.02(3A) and 7-1301.03(8D), and as amended by D.C. Law 24-117, the "Developmental Disability Eligibility Reform Amendment Act of 2022", means a severe and chronic disability of a person that:
(A) Is attributable to a mental or physical impairment, other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments;
(B) Is manifested before 22 years of age;
(C) Is likely to continue indefinitely;
(D) Results in substantial functional limitations in 3 or more of the following areas of major life activity:
(i) Self-care;
(ii) Understanding and use of language;
(iii) Functional academics;
(iv) Social skills;
(v) Mobility;
(vi) Self-direction;
(vii) Capacity for independent living; or
(viii) Health and safety; and
(E) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are person-centered, planned, and coordinated.

Intellectual Disability or Persons with Intellectual Disabilities, as defined in D.C. Official Code §§ 7-761.02(7A) and 7-1301.03(15A), and as amended by the Developmental Disability Eligibility Reform Amendment Act of 2022, means a person that is diagnosed before 22 years of age with an intellectual disability as set forth in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

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 Evaluations:

1) The DDS/DDA Intake and Eligibility Determination Unit service coordinator will complete the DC LON based on information obtained in all required documentation listed in the current DDS/DDA policy and procedure to include the DDA Intake application, psychological evaluation and if available medical examination, social history, school records, vocational assessments, and/or other available background information and interviews. The DC LON is a comprehensive assessment tool, which documents and individual's health, developmental and mental health diagnoses, and support needs in all major life activities to determine the level of care determination criteria specified in (b) 1-8 and (c) 1-8 above.

2) The "additional conditions" specified in the level of care determination criteria in (b) 2,3,5,6,7,8 are found in the DC LON at questions 15 and 16. The criteria for (b) 1 is considered met if the individual receives a score of 2 or higher on the Mobility scale in the DC LON Summary Report, and (b) 4 is considered met if the individual receives a score of 2 or higher on the PICA, Behavior or Psychiatric scale in the DC LON Summary Report.

3) The criteria for severe functional limitations in the following major life activities specified in the level of care criteria in (c) is considered met by the following scores in the DC LON Summary Report:

a) Self-Care - Score of 3 (out of 8) or higher in Personal Care;
b) Understanding and Use of Language- Score of 1 (out of 4) or higher in Communication;
c) Functional Academics- refer to the Psychological evaluation;
d) Social Skills- Score of 3 (out of 7) or higher in Social Life;
e) Mobility- Score of 1 (out of 7) or higher in Mobility;
f) Self-Direction-Score of 1 (out of 3) or higher in Comprehension and Understanding;
g) Capacity for Independent Living-Score of 2 (out of 6) or higher in Daily Living; and
h) Health and Safety- Score of 2 (out of 7 or higher) in Health or 2 (out of 7) or higher in Safety.

4) At the time the person who has been found eligible for DDA services seeks to receive those services through the HCBS IDD waiver program, the DDS/DDA service coordinator submits the waiver application package, inclusive of all required documentation listed in the current DDS/DDA policy and procedure, to the DDS/DDA designated staff to complete the initial level of care determination as part of the eligibility review for the HCBS IDD waiver program.

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:

In addition to the QIDP or QDDP qualifications, an individual must also have three years experience supporting or working with people with intellectual disabilities.

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):*

Timely reevaluation means a Level of Care (LOC) reevaluation is completed before the effective date of the annual ISP. The LON assessment must be updated at least annually as part of the annual ISP review and LOC redetermination processed by the person's support team for persons enrolled in the IDD HCBS waiver program.

The DDA service coordinator is responsible for informing persons of all waiver services and offering a choice of service and providers to persons during the planning process. The DDA service coordinator will also provide persons with a fact sheet about abuse and neglect. The DDA service coordinator is responsible to ensure the LON assessment and report are updated on at least an annual basis, or, whenever there is a significant change in a person's support needs as part of a review and/or amendment to the ISP if needed. On time for LOC re-evaluation is defined as being completed on or before the effective date of the annual ISP.

To ensure that a person's waiver eligibility is verified prior to issuing service authorization, the DDA Health Insurance Analyst or Medicaid Waiver Specialist completes and submits the Medicaid recertification form to the Economic Security Administration (ESA) at least 60 days prior to the expiration of the person's Medicaid eligibility period for a determination of current financial eligibility

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:

Written documentation of each evaluation and reevaluation are maintained by DDS, in MCIS/the applicable DDS electronic information system, for a minimum of (3) three years, except when there is an audit or investigation, in which case the records are maintained by DDS until the review has been completed.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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:
LOC.i.a.i.PM.1. Percentage of all people seeking services in addition to service coordination from DDS, for whom there is a reasonable indication that services will be needed in the future, will receive an evaluation for the ICF/IDD level of care. Number of people who have a LOC (numerator)/Number of people who seek services in addition to service coordination (denominator).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Intake Database, MCIS/Applicable DDS electronic information system

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

Performance Measure:
As per CMS guidelines issued in September 2013, a Performance Measure for LOC

re-evaluation is not required

Data Source (Select one):
Other
If 'Other' is selected, specify:
N/A

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

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: N/A	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: N/A

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:
LOC.i.c.i.PM.1. The evaluation for the level of care including the Level of Need and Risk Assessment is completed consistent with the approved waiver. N= Number of people whose initial Level of Care evaluation includes a completed LON and risk assessment D= No. of new people enrolled in waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCIS/Applicable DDS electronic information system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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.

LOC.i.a.i.PM.1. All people seeking services from DDA will receive an evaluation for the ICF/IDD level of care. (Number of people who have a LOC/number of people who seek services (in addition to service coordination.)

The DDS/DDA Intake and Eligibility Unit will denote in the Intake Database those people seeking services for whom there is reasonable indication that services may be needed in the future (in addition to service coordination). Prior to the submission of the waiver packet, the Intake and Eligibility Unit requests a waiver attestation form from the waiver unit after eligibility determination. The Intake and Eligibility Unit transfers all eligible individuals to the Service Planning and Coordination Division. When the service coordinator completes the initial ISP, he/she will document in the initial ISP if the person is seeking services at that time. If the person is, the service coordinator will complete the documents necessary for an initial level of care determination and submit it to the DDA Waiver Unit to complete the evaluation. Then the service coordinator will inform the individuals about all available waiver services and provide them with a fact sheet about abuse and neglect. The designated staff will complete the level of care determination.

Quarterly, the DDS/DDA Intake and Eligibility Unit will report the names of people for whom there was a reasonable indication that services and service coordination may be needed in the future, to DHCF. Recommendations for remediation and improvement, as applicable, will be made by DHCF and reported to DDS/DDA following the quarterly audit for action.

Quarterly, the DDS/DDA Intake and Eligibility Unit will report the names of people for whom there was a reasonable indication that services and service coordination may be needed in the future, to DHCF.

DHCF will complete a confidence level review of 100% based on information from the MCIS Intake Database for the people seeking waiver services on a quarterly basis.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

As part of the routine supervisory activities, the DDA Service Coordinator will conduct a review of the accuracy of the level of care determinations and timeliness. When issues are identified they will be managed by the supervisor.

When members of the DHCF IDD Team identify a problem, they report the problem to DDS/DDA for analysis and corrective action as needed throughout the approved Discovery/Remediation process. The DDS Deputy Director for DDA designee will be responsible for ensuring the individual correction is made and will notify DHCF of actions completed. DHCF will request verification of the individual/systemic problem as warranted. DHCF will conduct review corrective actions to verify whether DDS has effectively addressed any individual or systemic problems.

Quarterly, DHCF staff assigned to monitor compliance with the level of care (LOC) assurance will review the list of names provided by DDA and check for those that may need services in the future and those that are indicated as needing an annual level of care determination.

As part of the discovery process, DHCF will use their Level of Care Assurance Tool to document all instances and findings where it is determined that level of care criteria was not met and/or the participant did not receive a re-evaluation as required.

Following implementation of its discovery process, problems and issues identified by DHCF will be shared with DDS, along with recommendations for remediation and improvement within specified timelines.

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**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

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).

Individuals are offered the choice of either institutional or Home and Community Based Services at their initial ISP meeting with their assigned service coordinator. At that meeting, individuals are informed of the availability of this waiver and the Individual and Family Support (IFS), all available waiver services and will provide the link to the DDS website that identifies all waiver providers. Upon being made aware that a person/family does not have internet access or lacks the capacity to navigate the DDS website, service coordinators print related documents and explains each service the person is eligible to receive. The service coordinator also provides service descriptions to each individual, and if needed schedules meetings with prospective providers. Service descriptions are also found on the DDS website at www.dds.dc.gov. An HCBS waiver fact sheet is also available for individuals and stakeholders. Individuals are afforded freedom of choice in their selection of receiving support services remotely and/or in-person.

Service Coordinators as part of the initial eligibility determination for the waiver shall inform the person and/or legal guardians of the choice between HCBS waiver services and ICF/ID institutional services. Freedom of choice is also maintained throughout the service delivery process as changes in providers are needed to address varying support needs. The Service Coordinator is expected to answer questions on HCBS waiver services as well as ICF/ID services.

The enrollment into the IDD waiver is based on the individuals' identified needs. The Interdisciplinary Team (IDT) will discuss services based on the individuals' specified need(s) and the most appropriate waiver will be explored.

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.

The Department on Disability Services uploads the signed copy of the Freedom of Choice II document into the MCIS/applicable DDS electronic information system . The forms are maintained for a minimum of three years.

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 Language Access Act of 2004, enacted by the Council of the District of Columbia, requires that all District government programs, departments and services assess the need for, and offer, oral language services, provide written translations of documents into any non-English language spoken by a limited or non-English proficient population that constitutes 3% or 500 individuals (whichever is less) of the population served or encountered, or likely to be served or encountered; ensure that District government programs, departments, and services with major public contact establish and implement a language access plan and designate a language access coordinator; require that the Office of Human Rights coordinate and supervise District government programs, departments, and services in complying with the provisions of this act and establish the position of Language Access Director for this purpose; amend the District of Columbia Latino Community Development Act; and repeal the Bilingual Services Translation Act of 1977 to repeal redundant provisions.

Pursuant to Chapter 42 of Title 29, each provider of Waiver services shall establish a plan to adequately provide services to non-English speaking individuals. The provider shall identify the necessary resources and individuals in order to implement the plan.

DHCF monitors a sample of five providers on a quarterly basis to verify that providers are complying with DDS's language access policy. If the providers support individuals with limited English proficiency, DHCF verifies that there are accommodations for these people that enable ongoing communication throughout service delivery. DHCF also reviews the provider's language access policy to ensure that the provider follows General Provision Waiver Rules and the DDS Language Access Policy.

DDS is monitoring the implementation of the language access policy through its use of provider monitoring tools completed by quality resource specialists. These tools are used with enrolled waiver providers that are qualified to deliver supports and services to individuals served through the HCBS waiver and collect information on the provider's compliance with the DDS Language Access Policy, staff training and procedures when additional assistance is required from DDS to meet a specific need.

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	**Day Habilitation**		
Statutory Service	**Employment Readiness**		
Statutory Service	**In-Home Supports**		
Statutory Service	**Residential Habilitation**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment**		
Extended State Plan Service	**Personal Care Services**		
Extended State Plan Service	**Skilled Nursing**		
Other Service	**Assistive Technology Services**		
Other Service	**Behavioral Supports**		
Other Service	**Companion Services**		
Other Service	**Creative Arts Therapies**		
Other Service	**Dental**		
Other Service	**Family Training**		
Other Service	**Health Assessment and Coordination**		
Other Service	**Host Home**		
Other Service	**Individualized Day Supports**		
Other Service	**Occupational Therapy**		
Other Service	**One-Time Transitional Services**		
Other Service	**Parenting Supports**		
Other Service	**Personal Emergency Response System (PERS)**		
Other Service	**Physical Therapy**		
Other Service	**Small Group Supported Employment**		
Other Service	**Speech, Hearing and Language Services**		
Other Service	**Supported Living with Transportation**		
Other Service	**Supported Living**		
Other Service	**Wellness 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:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Day Habilitation Services are aimed at developing activities and/or skills acquisition to support or further integrate community opportunities outside of an individual's home, to foster independence, autonomy or career exploration and encourage development of a full life in his/her community. Services are in group settings, but within these settings, individuals may receive services as part of a group or on an individualized basis.

Community outings may occur in groups without limitation to size but must be based on the people's interests and preferences. Individualized community integration and/or inclusion activities must occur in the community in groups that do not exceed 4 participants and must be based on the people's interests and preferences. Services may be offered in a large group or a small group setting. The small group setting is for waiver recipients who are medically and/or behaviorally complex, as verified by the DDA Level of Need Assessment and Screening Tool (LON) score of 6 or more, or its successor and/or the person's Behavior Support plan, and who would benefit from day habilitation in a smaller setting. Small group day habilitation cannot be provided in the same building as a large day habilitation facility setting and must be located in places that facilitate community integration and inclusion. No more than 15 people can be supported in small day habilitation. Both group and individualized services are to enable the individual to attain maximum functional level based on his/her valued outcomes. These services should be provided in a variety of community venues that should routinely correspond with the context of the skill acquisition activity to enhance the habilitation activities. Overarching goals of the program shall include regular community inclusion and the opportunity to build towards maximum independent status for the person.

The primary focus of Day Habilitation Services is acquisition of new skills or maintenance of existing skills based on individualized preferences and goals. The service shall offer adult skill-building activities, including opportunities for community exploration, inclusion and integration, based upon the person's current, emerging and newly discovered interests and preferences. The activities shall support the acquisition of new skills as well as support for self-determination, the development of relationships, community integration, employment exploration and/or community contribution (including discussion of and general exposure to different types of employment with the goal being to enable a person to identify and develop interests, cultivate relevant skills, and seek out training). The skill acquisition/maintenance activities should include formal strategies for teaching the individualized skills and include the intended outcome for the individual. Individualized progress for the skill acquisition/maintenance activities should be routinely reviewed and evaluated with revisions made as necessary to promote continued skill acquisition. As a person develops new skills, his or her training should move along a continuum of habilitation services offered toward greater independence and self-reliance.

Personal care may be a component of day habilitation services as necessary to meet the needs of a person, but may not comprise the entirety of the service.

Day Habilitation Services shall focus on enabling people served through the waiver to attain their maximum functional level and shall be coordinated with any physical, occupational or speech therapies listed in the individual's Plan of Care. In addition, Day Habilitation Services may serve to reinforce skills or lessons taught in school, therapy, or other settings. Provision of a hot meal, including preparation, packaging, and delivery to the day habilitation program, shall be provided for participants who live in his/ her own or family home. The provision of meals shall take place during typical lunchtime hours

(11am-1pm). In order to receive this service, the person must be identified as having difficulty in shopping and/or preparing appropriate, nutritious meals. This meal shall be nutritionally adequate and prepared based on the person's specific needs as per the LON and, when necessary, the nutritionist/doctor's recommendation. This meal must meet one-third (1/3) of a person's Recommended Dietary Allowance (RDA) and must comprise of foods the person enjoys eating when not medically contraindicated. The meals provided as part of Day Habilitation services shall not constitute a full daily nutritional regimen.

Day Habilitation services will also include a nursing component to provide medication administration, staff training on components of the Health Care Management Plan, and oversight of Health Care Management Plans. Day Habilitation services will also include a nutritionally adequate meal for participants who live independently or with their families and who select to receive a meal.

Time spent in transportation to and from the service shall not be included in the total amount of services provided per day. Time spent in transportation during activities is reimbursed under day habilitation.

Day Habilitation 1:1, day habilitation, and small group day habilitation remote support staffing ratio are 1:6 and must have active, continuous engagement and contact with the remote support platform.

Services may be offered in a large group or a small group setting.

Day Habilitation Services provided via remote support:

This service may be rendered using remote support. The purpose of the remote support delivery option is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and promote their ability to live independently, and meaningfully participate in their community. The participant's services may not be delivered virtually one hundred (100) percent of the time. The participant must always have the option to utilize in-person services. A participant who requires in-person assistance during the provision of the service must receive services in person. The use of the remote delivery service option is not for the convenience of providers.

Requirements and methodology regarding HIPAA have been approved by the DC HIPAA Compliance Officer. Participant privacy rights will be assured and monitored on an ongoing basis. Privacy obligations will be reviewed on an ongoing basis with providers and the person receiving services. Training will be provided for participants on how to identify or report issues if they believe their privacy has been violated. Providers will not use video or remote support devices in participant bedrooms or bathrooms. The use of the virtual support option must not block, prohibit or discourage the use of in-person services or access to the community. Community integration will be increased by having the option for remote service delivery. In instances where participants may not be inclined to attend or receive a service in-person, the remote service delivery option affords the opportunity for the participant to still participate in services, engage with their providers, community and friends, when they otherwise would not be able to do so due to illness, transportation issues, pandemics, or other personal reasons.

Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the remote delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The Individual Support Plan (ISP) must include a justification statement explaining how remote support assures health and safety If it is determined that in-person assistance is required, virtual support may not be provided.

Day habilitation provided via remote support shall consist of the following age-appropriate learning and/or habilitative activities that are based on what is important to and for the person as documented in the person's ISP and reflected in their Person-Centered Thinking and Discovery tools:

(a)Training and skills development that increase participation in community activities, enhance community inclusion, and foster greater independence, self-determination, and self-advocacy;
(b)A diversity of activities that allow the person the opportunity to choose and identify his or her own areas of interest and preferences;
(c)Activities that provide opportunities for socialization and leisure activities in the community, community explorations, and activities that support the person to build and maintain relationships;
(d)Training in the safe and effective use of one or more modes of accessible public transportation;
(e)Activities to support community integration and inclusion,
(f)Individualized or group services that enable the person to attain his/her maximum functional level based on the ISP and Plan of Care.

Staff-to-person ratio shall be 1:1 or 1:4 for day habilitation and 1:3 for small day habilitation, as reflected in a person's Individual Support Plan and Plan of Care. Staff should be available during the service hours and document that they are continuously engaged with the person and/or the remote supports responder platform to bill for hourly services rendered.

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

This service is delivered no more than 40 hrs per week, in combination with any other waiver day or vocational support services, including Employment Readiness (Empl Rd), Small (Sm) Group Supported Employment, or Individualized (Ind) Day Supports. Provisions must be made by the provider for persons who arrive early and depart late.

Day Habilitation rates includes nursing oversight for medication administration, physician-ordered protocols & procedures, charting, other supports as per physician orders and maintenance of Health Management Care Plan.

(1) People who are 64 and younger and have a LON ay Composite score of 2 or less would not be eligible to attend Day Hab, unless approved by DDS due to extenuating circumstances or barriers that are expected to be resolved within six months. Exceptions may only be granted for 6 month periods and must be accompanied by an Individual Support Plan goal aimed at addressing the barrier to participation in other day or employment waiver supports. Alternative services, including Empl Rd, Sm Group Supported Employment, Ind Day Supports, and Companion services that are offered during regular day service hours, would be available, in combination, for up to forty hours per week.

2) People who are 64 and younger and have a LON Composite score of 3 or higher would not be eligible to attend Day Hab programs, unless they have tried other day and employment options for one year first unless approved by DDS due to extenuating circumstances or barriers that are expected to be resolved within six months. Exceptions must be accompanied by an ISP goal aimed at addressing the barrier to participation in other day or employment waiver supports. This is not applicable to Sm Group Day Hab services. Alternative services including Supported Empl, Ind Day Supports, Emp Rd and Companion would be available in combination for up to forty hours per week.(3) Day Hab services may not be authorized for any waiver participant for more than 24 hours per week. Wrap around services are available, including Supported Empl, Ind Day Supports, Empl Rd and Companion in combination for up to forty hours per week. This limit is not applicable to Sm Group Day Hab services.

Requirements for New Non-Sm Group Day Hab Setting:
1) Any new non-sm group Day Hab Setting must fully comply with the requirements of the HCBS Settings Rule.
2) No new Day Hab setting may exceed a daily census in the setting of 50, inclusive of people who receive support through the IDD Waiver and people who receive ICF/IDD supports and are engaged in active treatment at the setting.

Daily Census Limits for Existing Non-Sm Group Day Hab Programs:

1) Current non-sm group Day Hab settings that have a daily census under 50, may only receive authorizations for services for new participants up to a daily census of 50 in the setting. The daily census is inclusive of people who receive support through the IDD Waiver and people who receive ICF/IDD supports and are engaged in active treatment at the setting. The daily census does not include people who are in the setting only for morning arrival and afternoon departure and who spend the remainder of the day in the community.

2) Current non-sm group Day Hab settings that have a daily census of 50 people or more will not be eligible for authorizations for services for new participants until their daily census is under 50 people in the setting. The daily census is inclusive of people who receive support through the IDD HCBS Waiver and people who receive ICF/IDD supports and are engaged in active treatment at the setting. The daily census does not include people who are in the setting only for morning arrival and afternoon departure and who spend the remainder of their day in the community.

3) All Day settings must comply with HCBS Settings Rule.

4) No increase to the number of facility-based settings will be authorized for current providers. No facility-based settings will be authorized for newly enrolling providers, except for small group day hab providers.

This service can be provided using remote support no more than four (4) hours per day.

This service cannot be delivered remotely one hundred (100) percent of the time.

The IDT will need to assess the person's ability to benefit from remote services engagement to determine how many hours the person can engage in remote supports for day habilitation. Day Habilitation services can be implemented partially in-

person and partially remote supports.

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

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

☑ **Provider managed**

☑ **Remote/via Telehealth**

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	Day Habilitation

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Day Habilitation

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by DDS as a Day Habilitation provider agency in accordance with DDS Provider Certification Review Standards.

Other Standard *(specify):*

"Program managers of provider agencies must have at least three years of experience working with people with IDD who are medically and/or behaviorally complex."

Each day habilitation services provider shall:

(a) Meet the applicable requirements to conduct business in the state in which the provider delivers service;
(b) Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for Day Habilitation Services;
(c) Ensure that all staff are qualified and properly supervised;
(d) Ensure that the service provided is consistent with the persons' ISP/POC, and that services are coordinated with all other providers;
(e) Develop a quality assurance system to evaluate the effectiveness of services provided;
(f) Maintain the required staff-to-person ratio, indicated on the person's ISP/POC, to a staffing ratio of 1:1 and 1:4 for day habilitation and 1:3 for small group day habilitation.
(g) Participate in the annual ISP/POC meeting;
(h) Ensure that services are provided appropriately and safely;
(i) Develop a staffing plan which includes licensed professionals, where applicable and appropriate;
(j) Maintain records that document staff training and licensure, for a period of not less than six (6)years;
(k) Offer the Hepatitis B vaccination to each person providing services, pursuant to these rules;

(l) Provide training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor, as set forth in 29 C.F.R. §1910.1030; Owner-operators shall complete training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics determined by DDS, and in accordance with DDS published guidance within one year from the date the waiver application becomes effective for current providers and prior to any new waiver provider becoming approved to initiate services; and (m) Provide interpreters for non-English speaking persons and those with hearing impairments that are enrolled in the program.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

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:

Prevocational Services

Alternate Service Title (if any):

Employment Readiness

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Employment Readiness Services provide learning and work experiences, including volunteer work, where the person can develop general, non-job- task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. The activities shall support the acquisition of new employment-related skills, including soft skills such as self-determination, benefits counseling, the development of relationships, and employment exploration in the community. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by

the person and his/her service, and the supports planning team through an ongoing person-centered planning process. Employment Readiness Services should enable each person to attain the highest level of work in the most integrated setting and with the job matched to the person's interests, strengths, priorities, abilities, and capabilities.

Employment Readiness Services may be furnished in a variety of locations in the community and are not limited to fixed-site facilities. No increase to the number of facility-based settings shall be authorized. Current providers will be prohibited from increasing the number of facility-based settings at which services are provided, and newly enrolling providers shall be prohibited from providing services at any facility-based settings.

A person receiving Employment Readiness Services may pursue employment opportunities at any time to enter the general workforce. Employment Readiness Services are intended to assist individuals to enter the general workforce. Personal care/assistance may be provided by the provider of employment readiness services as a component of this service, but may not comprise the entirety of the service.

Individuals receiving Employment Readiness Services must have employment-related goals in their person-centered services and supports plan and the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which a person is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by people without disabilities, is considered to be the optimal outcome of Employment Readiness Services.

Employment Readiness Services are intended to develop and teach general skills. Examples of Employment Readiness Services include, but are not limited to: ability to communicate effectively with supervisors, coworkers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem-solving skills and strategies; and, general workplace safety and mobility training.
In the event that persons served through the waiver are compensated in employment-related training services, pay must be in accordance with the United States Fair Labor Standards Act of 1985. Persons served through the waiver who express interest in working in a competitive job setting are supported when transitioning to a more appropriate vocational opportunity by the Employment Readiness provider and Service Coordinator.

The Employment Readiness staffing ratio is based on the person's staffing needs, as indicated in the person's Individual Support Plan (ISP) and Plan of Care (POC), which is either 1:1 or 1:4 for employment readiness.

Employment Readiness Services provided via remote support:

This service may be rendered using remote support. The purpose of the remote support delivery option is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and promote their ability to live independently, and meaningfully participate in their community. The participant's services may not be delivered virtually one hundred (100) percent of the time. The participant must always have the option to utilize in-person services. A participant who requires in-person assistance during the provision of the service must receive services in person. The use of the remote delivery service option is not for the convenience of providers.

Requirements and methodology regarding HIPAA have been approved by the DC HIPAA Compliance Officer. Participant privacy rights will be assured and monitored on an ongoing basis. Privacy obligations will be reviewed on an ongoing basis with providers and the person receiving services. Training will be provided for participants on how to identify or report issues if they believe their privacy has been violated. Providers will not use video or remote support devices in participant bedrooms or bathrooms. The use of the virtual support option must not block, prohibit or discourage the use of in-person services or access to the community. Community integration will be increased by having the option for remote service delivery. In instances where participants may not be inclined to attend or receive a service in-person, the remote service delivery option affords the opportunity for the participant to still participate in services, engage with their providers, community and friends, when they otherwise would not be able to do so due to illness, transportation issues, pandemics, or other personal reasons.

Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the remote delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The Individual Service Plan (ISP) must include a justification statement explaining how remote support assures health and safety If it is determined that in-person assistance is required, virtual support may not be provided.

Employment Readiness remote support services provide learning and work experiences, including volunteer work, and

support persons on their pathway to competitive, integrated employment and consist of the following:

(a)Providing opportunities for persons enrolled in the Waiver to develop general, non-job, task-specific strengths and skills that contribute to employability and are consistent with the person's goals;
(b)Assessment activities that occur annually or more frequently based upon the needs of the person, which require, at a minimum, a Positive Personal Profile and Job Search and Community Participation Plan, and may also include a customized employment assessment, and/or conducting a person-centered vocational and situational assessment and employment readiness assessments provided at community businesses and other community settings;
(c)Social and soft skills training, including, but not limited to, the following:

(1)Following and interpreting instructions;
(2)Interpersonal skills, including building and maintaining relationships;
(3)Communication skills for communicating with supervisors, co-workers, and customers;
(4)Travel skills;
(5)Respecting the rights of others and understanding personal rights and responsibilities;
(6)Decision-making skills and strategies;
(7)Support for self-determination and self-advocacy; and
(8)Budgeting and money management;

(d)Developing work skills which shall include, at a minimum, teaching the person the following:
(1)Appropriate workplace attire, attitude, and conduct;
(2)Work ethics;
(3)Attendance and punctuality;
(4)Task completion;
(5)Job safety;
(6)Attending to personal needs, such as personal hygiene or medication management; and
(7)Interviewing skills;

(e)Coordinating transportation to community activities utilizing the Medicaid Non-Emergency Transportation Broker;
(f)Employment exploration and/ or employment preparation in the community; and
(g)Coordinating community-based, integrated, volunteer experiences.

Employment Readiness remote support staffing ratio is 1:6 and must have active, continuous engagement and contact with the remote support platform. Staff should be available during the service hours and document that they are continuously engaged with the person and/or the remote supports responder platform to bill for hourly services rendered.

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

Services are not available to people who can be fully supported individuals in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401 (16) and (71), but may be used to wrap around those programs.

Any new Employment Readiness setting must be fully compliant with the requirements of the HCBS Settings Rule.

Current Employment Readiness settings that have a daily census under fifty people in the setting for more than 20% of the day, may only receive authorizations for services for new participants up to a daily census of fifty people in the setting. The daily census is inclusive of people who receive support through the IDD HCBS Waiver and people who receive ICF/IDD supports and are engaged in active treatment at the setting. There are no current Employment Readiness settings with a daily census of more than 50 people in the setting.

Time limitations on use of Employment Readiness services:

For people who are not currently enrolled in Employment Readiness services, the service may only be authorized for up to one year, except that DDS may approve up to a one year extension if there is documentation that the person is making progress towards competitive integrated employment and would benefit from extended services.

If a person has exhausted Employment Readiness services and: (1) has had at least one year since the end of that service; (2) expresses an interest in employment; and (3) the support team has identified specific goals around building employment skills that are reflected in the ISP, then DDS may authorize Employment Readiness services one time, for up to one year. (Total of up to three years of Employment Readiness services.)

Exception: At any time that a person loses his or her job, or is employed and is seeking to learn new job skills, DDS may authorize Employment Readiness services for up to one year.

Medicaid reimbursement employment readiness services shall not be provided, or billed at the same time as the following services: day habilitation, supported employment, in-home supports, companion, personal care services, and individualized day supports.

The employment readiness service includes transportation furnished by the provider during the course of the service. While the State Plan includes a transportation benefit, and providers under that benefit are capable of transporting IDD Waiver individuals, this benefit is only used by IDD waiver beneficiaries to reach the employment readiness site. This is because the State Plan transportation benefit cannot provide real-time services dedicated to a particular provider's needs. State Plan transportation services are coordinated by a non-emergency medical transportation broker. The service must be reserved in advance, and trips often include other non-IDD waiver beneficiaries on their way to a variety of destinations. As a result, it is not practical for a beneficiary to rely on transportation arranged by the broker during an episode of an employment readiness service. The employment readiness service covers such transportation, and it is separate and distinct from the State Plan transportation service generally.

There shall be no increase to the number of facility-based settings shall be authorized. Current providers will be prohibited from increasing the number of facility-based settings at which services are provided, and newly enrolling providers shall be prohibited from providing services at any facility-based settings.

This service can be provided using remote support no more than four (4) hours per day. The IDT will need to assess the person's ability to benefit from remote services engagement to determine how many hours the person can engage in remote support for employment readiness. Employment readiness services can be implemented partially in-person and partially remote supports.

Services cannot be delivered remotely one hundred (100) percent of the time.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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	Employment Readiness

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Employment Readiness

Provider Category:

Agency

Provider Type:

Employment Readiness

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DDS Provider Certification Review per DDS Policy

Certified Enabling Technology Integration Specialist (ETIS) employed by a Shift DDS Service Provider. Shift is the developmental and disability services industry's first online learning curriculum and community that standardizes best practices in Technology First programming. The program is accredited by the National Association of Direct Support Professionals. Currently, it includes two (2) programs:

1. Enabling Technology Integration Specialist Certification that provides specialized training in person-centered technology assessment and implementation; and

2. Technology First Accreditation for organizations demonstrating sustainable and standardized best practices in enabling technology integration.

Other Standard *(specify):*

Each Employment Readiness services provider shall:
- Be a home health agency, social service agency, or other business entity;
- Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for prevocational services under the Waiver;

Owner-operators shall complete training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics determined by DDS, and in accordance with DDS published guidance within one

year from the date the waiver application becomes effective for current providers and prior to any new waiver provider becoming approved to initiate services.

"Provider must be enrolled as a provider for Rehabilitation Services Administration (RSA) within one year of becoming an Employment Readiness provider for new providers.

For individual employees, the following requirements apply:
- Documentation that each employee is eighteen (18) years of age or older;
- Documentation from a physician or other official stating that the employee is free from communicable disease as confirmed by a purified protein derivative of tuberculin (PPD) Skin Test in accordance with current Centers for Disease Control (CDC) guidelines;
- Record of completion of competency-based training in communication with people with intellectual disabilities;
- Record of completion of competency-based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030;
- A high school diploma or general equivalency development;
- (GED) certificate from English speaking program or ESL certificate;
- Record of completion of competency-based training in emergency procedures;
- Certification (active) in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDS-approved pre-service and in-service training in DDS policies and procedures;
- Training needed to address the unique support needs of the individual as detailed in their ISP.

For direct support professionals providing 1:1 employment readiness services, the following requirements apply:

Be trained in physical management techniques, positive behavioral support practices, and other training required to implement the person's health care management plan and behavioral support plan (BSP), in accordance with DDS's Training policy and procedure;

Accurately complete the behavioral data sheets when required by a person's BSP.

Within one year of becoming an employment readiness provider:

The provider shall maintain evidence of completion of a professional development course that will satisfy a Basic Employment Certificate or comparable as required by the Association of Community Rehabilitation Educators (ACRE).

In addition to the requirements stated above, for all staff working directly with persons with disabilities, particularly in job development and placement, the following topic areas should be covered by the course or training and obtained within a year:

o Application of Core Values and Principles to Practice or Federal Policy and Historical Perspective required four (4) hours

o Individualized Assessment and Employment/ Career Planning or Customer Profile and Employment Selection required six (6) hours
o Community Research and Job Development or Organizational Marketing and Job Development required five (5) hours
o Workplace and Related Supports or Job-Site Training required ten (10) hours
o Others (Specific Disabilities, Long Term Support, Funding, Benefits Counseling, etc.) required ten (10) hours
o The total hours of these services are forty (40) hours.

This training requirement may be waived if the staff possesses a National Certificate in Employment Services or is a Certified Employment Support Professional.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially, and annually thereafter

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:

Habilitation

Alternate Service Title (if any):

In-Home Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

In-Home Supports are provided to a person living independently or with family or friends and not receiving other residential supports such as Supported Living, Supported Living with Transportation, Residential Habilitation, or Host Home support services to assist them with residing successfully in and be a part of the community.

In-Home Supports may also be offered as "High Acuity In-Home Supports" for people with more complex medical and/ or behavioral health needs, as evidenced by the Level of Need Screening and Assessment Tool with a LON score of 6 or higher, or its successor, to provide enhanced nursing oversight and healthcare coordination.

In-Home Supports focus on achieving one or more goals as outlined in the approved Plan of Care utilizing teaching and support strategies. Specified goals are related to acquiring, retaining, and improving independence, autonomy, and adaptive skills. The service shall offer adult skill building activities, including opportunities for community exploration, inclusion and integration, based upon the person's current, emerging and newly discovered interests and preferences. The activities shall support the acquisition. Examples of trainings include the following:
• Self-help skills, including activities of daily living and self-care;
• Socialization skills to foster community inclusion and well-being;
Implementation of home therapy programs under the direction of a licensed clinician;
•Cognitive and Communication Tasks Adaptive Skills; and
•Replacement Behavior Components of Positive Behavior Support Plans, including those skills required to effectively address situations and antecedents of frequently occurring maladaptive or challenging behavior. In-Home Supports providers may work as directed by an assigned professional to assist the individual to develop skills necessary to reduce or eliminate episodes in which the individual becomes a danger to self or others.
•Community exploration aimed at discovery of new and emerging interests and preferences.
•Community activities aimed at supporting the person to have one or more new relationships.
•Supporting the person to build community membership.

In-home supports services include a combination of hands-on care, habilitative supports, skill development and assistance with activities of daily living. Supports provided shall be aimed at teaching the person to increase his or her skills and self-reliance.

Payment will not be made for routine care and supervision that is normally provided by the family or for services furnished to a minor by the child's parent or step-parent or by an individual's spouse. Family members who provide In-Home Supports must meet the same standards as providers who are unrelated to the individual. Payment does not include room and board, maintenance, or upkeep and improvement of the individual's or family's residence.

Payment will not be made for travel or travel training to Supported Employment, Day Habilitation or Employment Readiness Services.

This service includes 24-hour availability of response staff to meet schedules or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

A temporary emergency occurs when an individual and/or family are in a predicament and there are no other natural or community resources available to support the person, and the person requires in-home support hours in excess of the 56hours per week limitation. These can include but not limited to from the person requiring additional supports returning home from hospitalization and/or rehabilitation; the primary caretaker has fallen ill and had to be hospitalized or has died etc. In the event of a temporary emergency, a written justification for an increase in hours shall be submitted with the In-Home Supports Plan, ISP, and Plan of Care by the provider to DDS. The written justification must include a description of the temporary emergency; an explanation of why no other natural or community resources are available; an explanation of how the additional hours of in-home supports services will support the person's habilitative needs; a revised copy of the in-home Supports Plan reflecting the increase in habilitative supports to be provided which is submitted to the Medicaid Waiver Supervisor or other Department on Disability Services Administration designated staff for review and authorization.

In-Home Supports are not available to individuals receiving Host Home, Residential Habilitation or Supported Living services.

In Home Supports may be provided in person, or via remote support, where approved by the person and his or her support team, and documented in the ISP. This service may be rendered using remote support. The purpose of the remote support delivery option is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and promote their ability to live independently, and meaningfully participate in their community. The participant's services may not be delivered virtually one hundred (100) percent of the time the In-Home.

This service may be rendered using remote support. The purpose of the remote support delivery option is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and promote their ability

to live independently, and meaningfully participate in their community. The participant's services may not be delivered virtually one hundred (100) percent of the time the total In-Home Supports services that the person receives each week. The participant must always have the option to utilize in-person services. A participant who requires in-person assistance during the provision of the service must receive services in person. The use of the remote delivery service option is not for the convenience of providers. Requirements and methodology regarding HIPAA have been approved by the DC HIPAA Compliance Officer. Participant privacy rights will be assured and monitored on an ongoing basis. Privacy obligations will be reviewed on an ongoing basis with providers and the person receiving services. Training will be provided for participants on how to identify or report issues if they believe their privacy has been violated. Providers will not use video or remote support devices in participant bedrooms or bathrooms. The use of the virtual support option must not block, prohibit or discourage the use of in-person services or access to the community. Community integration will be increased by having the option for remote service delivery. In instances where participants may not be inclined to attend or receive a service in person, the remote service delivery option affords the opportunity for the participant to still participate in services, engage with their providers, community and friends, when they otherwise would not be able to do so due to illness, transportation issues, pandemics, or other personal reasons.

Qualified individuals may use In-Home Supports in combination with State Plan Personal Care and Home Health Services, as long as services are not provided during the same period in a day. The Service Coordinator is responsible for ensuring that no duplication of service occurs. The Service Coordinator will confirm with the person their PCA schedule to prevent duplication of services.

No person receiving PCA receives In Home Supports concurrently. Service coordinators understand that each service is unique and cannot be authorized for the same timeframes. The Level of Need (LON) requires a goal/service/strategy be associated with any risks identified. Goals are accomplished using personal strength, technology, HCBS, State Plan, and other identified community and natural supports.

As part of the person-centered planning process, the support team must discuss and create an individualized plan in the event that technology failures occur. In-home supports Direct Support Professional (DSP) services may be provided in an acute care hospital setting for the purposes of supporting the IDD waiver recipient's personal, behavioral and communication supports not otherwise provided in that setting. Services may not be duplicative of hospital or short-term institutional services. The District has mechanisms in place to prevent duplicate billing for both institutional and home and community based services. These necessary waiver services:
a. Must be identified in the person's Individual Support Plan (ISP);
b. Must be provided to meet the person's needs that are not covered in such settings;
c. Should not substitute for services that the setting is is obligated to provide through its condition of participation under federal or D.C. law, and/or under another applicable requirement; and
d. Should be designed to ensure smooth transitions between the setting and the home community-based setting and preserves the person's functional abilities.

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

In-home supports services shall only be provided for up to 56 hours per week unless there is a temporary emergency. In the event of a temporary emergency, DDS may authorize up to 112 hours per week for up to 180 days until the situation has stabilized during the persons ISP year and written justification must be included. Forty (40) or more hours per week of in-home supports to meet goal-oriented needs will be considered based on assessed need. People can receive 40 or more hours of in-home supports per week if they have significant needs and meet the criteria of support with ADLs, behavioral support, medical/health, safety and risk, and level of independence, as justified and documented in outcomes and goals in the ISP and in-home supports plan. Requested in-home support hours must directly support goals outlined in the ISP. The hours must be proportionate to the time needed to work on objectives or activities, ensuring the hours match the complexity of the tasks.

Personal care services under the ID/DD Waiver can only be accessed after all available personal care services provided under the State Plan for Medical Assistance (Medicaid State Plan) are exhausted. All medically necessary personal care and home health services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

The in-home supports service includes transportation furnished by the provider during the course of the service. While the State Plan includes a transportation benefit, this benefit cannot not provide real-time services dedicated to a particular provider's needs. State Plan transportation services are coordinated by a non-emergency medical transportation broker. The service must be reserved in advance, and trips often include other non-IDD waiver beneficiaries on their way to a variety of destinations. As a result, it is not practical for a beneficiary to rely on transportation arranged by the broker during an episode of an in-home supports service. The in-home supports service covers such transportation, and it is separate and distinct from the State Plan transportation service generally.

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

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

☑ **Provider managed**

☑ **Remote/via Telehealth**

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	Qualified Provider of In-Home Supports

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: In-Home Supports

Provider Category:

Agency

Provider Type:

Qualified Provider of In-Home Supports

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Satisfactory Completion of DDS Provider Certification Review per DDS Policy.

Certified Enabling Technology Integration Specialist (ETIS) employed by a DDS Service Provider. Shift is the developmental and disability services industry's first online learning curriculum and community that standardizes best practices in Technology First programming. The program is accredited by the National Association of Direct Support Professionals. Currently, it includes two (2) programs:

1. Enabling Technology Integration Specialist Certification that provides specialized training in person-centered technology assessment and implementation; and
2. Technology First Accreditation for organizations demonstrating sustainable and standardized best practices in enabling technology integration.

Other Standard *(specify):*

Agencies enrolled with DHCF as a Qualified Provider of In-Home Supports and hold a Medicaid Provider Agreement.
The owner and operator of the provider agency must have a degree in the Social Services Field or related field with at least three (3) years of experience working with people with intellectual and developmental disabilities (IDD) or five years (5) of experience working with people with IDD. Owner-operators shall complete training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics determined by DDS, and in accordance with DDS published guidance within one year from the date the waiver application becomes effective for current providers and prior to any new waiver provider becoming approved to initiate services.

For individual employees, the following requirements apply:
- Documentation that each employee is eighteen (18) years of age or older

- Annual documentation from a physician or other official that the employee is free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test;
- Record of completion of competency-based training in communication with people with intellectual disabilities
- Record of completion of competency-based training in infection control procedures consistent with the requirements of the Occupational - Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030.
- A high school diploma or general equivalency development
- Record of completion of competency-based training in emergency procedures
- Certification in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDS-approved pre-service and in-service training in DDS policies and procedures;
- Training needed to address the unique support needs of the individual as detailed in their Individual Support Plan; and
- Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), 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, $5 44-55 1 et seq.).

Sec. 12006 (a) of the 21st Century Cures Act mandates that states implement Electronic visit verification (EVV) system required for all Medicaid personal care services and home health care services that require an in-home visit by a provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially, and annually thereafter

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:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Settings that currently support 5 or 6 people will be targeted for reduction through attrition. As each person residing in these homes establishes a new annual ISP, DDS will offer the person a choice to move to another setting in order to reduce the number of people in all homes to 4 people. In addition, homes with 4 or more people will not be eligible for new referrals until their size is less than 4 people per setting.

All Residential Habilitation settings must fully comply with the requirements of the HCBS Setting Rule.

Services are developed in accordance with the needs of the person and include supports to foster independence and encourage development of a full life in the community, based upon what is important to and for the person, as documented in his or her Individualized Support Plan (ISP) and reflected in his or her Person-Centered Thinking tools. This includes assisting and teaching people to attain new and maintain and improve existing skills in areas including but not limited to self-care, daily living, adaptive, leisure, and community integration, including building and maintaining relationships.

Supports include health care, supervision, and oversight, including 24-hour availability of response staff to meet schedules or unpredictable needs in a way that promotes maximum dignity, independence, and ensuring that the person's need for skilled nursing services are met. The service provides supervision, safety, and security, but does not include the time the person is in school, day services, or is employed.

Residential Habilitation Rates include:
(a) All supervision from direct support staff;
(b) All nursing provided in the residence for medication administration, physician ordered protocols and procedures, charting, other supports as per physician's orders, and maintenance of Health Management Care Plan;
(c) Transportation;
(d) Programmatic supplies and fees;
(e) Quality Assurance costs such as Incident Management System and Staff Development and,
(f) General and Administrative fees for waiver services.

Acuity evaluation to set Support Levels will be recommended by the ISP team and approved by the DDS/DDA waiver unit through review of current staffing levels, available health and behavioral records, and any available standardized acuity instrument results to determine if a person has a health or behavioral acuity that requires increased supports. Individuals may be assessed at a Support Level that is consistent with their current staffing level if other Acuity indicators are not in place.

Payments are not made for room and board, the cost of facility maintenance, upkeep, or improvement. The cost of transportation is included in the residential habilitation rate. Skilled nursing in Residential Habilitation is accounted for in the rate for routine physical assessment, as needed, the development of Health Care Management plans, nursing assessments, as needed, oversight of non-licensed Medication Administration personnel or LPNs, and/or actual administration of medications. There is no service overlap, as Skilled Nursing is not authorized in Residential Habilitation settings as a separate Extended State Plan Service. Edits for Residential Habilitation are in the MMIS system to ensure there is no duplication or overlap of skilled nursing services.

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

This service may not be used in combination with any other waiver residential support service on the same day. This includes Supported Living, Host Home, In-home Respite, or In-home Supports. However, a person in Residential Habilitation may receive Personal Care Services if they are employed and/or in school.

Service may not be billed for more than 365 days a year.

Companion services can be used with Residential Habilitation services during regular daytime hours on Mondays through Fridays, not to exceed forty (40) hours per week, or in combination with any other waiver day or vocational support service, including Day Habilitation, Employment Readiness, Supported Employment, and Individualized Day Supports not to exceed forty (40) hours per week

No new residential habilitation settings that exceed the limit of four (4) persons will be authorized, unless determined essential by the DDA Deputy Director.
1. The District has mechanisms in place to prevent duplicate billing for both institutional and home and community based

services.
2. These necessary waiver services:
a. Must be identified in the person's Individual Support Plan (ISP);
b. Must be provided to meet the person's needs that are not covered in such settings;
c. Should not substitute for services that the setting is obligated to provide through its condition of participation under federal or D.C. law, and/or under another applicable requirement; and
d. Should be designed to ensure smooth transitions between the setting and the home community-based setting and preserves the person's functional abilities.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Residential Habilitation Agencies

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Residential Habilitation Agencies

Provider Qualifications

License *(specify):*

Home: Chapter 35 of Title 22 of the District of Columbia Municipal Regulations- "Licensure of Group Homes for Persons [with Intellectual Disabilities]"

Certificate *(specify):*

DDS Provider Certification Review per DDS Policy

Other Standard *(specify):*

Each provider of residential habilitation services shall:
- Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for residential habilitation services under the Waiver;
- Providers may have a current Human Care Agreement with DDS for the provision of residential services; and
- Ensure that the service provided is consistent with the persons ISP.

Owner-operators shall complete training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics determined by DDS, and in accordance with DDS published guidance within one year from the date the waiver application becomes effective for current providers and prior to any new waiver provider becoming approved to initiate services.

All employees must have:

- A Record of completion of competency based training in communication with people with intellectual disabilities;
- Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030;
- A high school diploma or general equivalency development;
- Record of completion of competency based training in emergency procedures;
- Certification in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures; and
- Training needed to address the unique support needs of the individual as detailed in their ISP
- Documentation that each employee is eighteen (18) years of age or older

No new residential habilitation settings that exceed the occupancy limit of four (4) persons will be authorized, unless determined essential by the DDA Deputy Director.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter.

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:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09011 respite, out-of-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Respite care provides relief to the family or primary caregiver to meet planned or emergency situations. Respite care gives the caregiver a period of relief for scheduled time away from the person, including vacations. It may also be used in case of emergencies. Respite care will ensure that persons served through the waiver have access to community activities as delineated in the person's ISP.

Respite is only provided to persons served through the waiver who live in their own home, or their family home. Respite may not be provided in the following settings: (1) an Intermediate Care Facility (ICF); a Residential Habilitation setting, if doing so would cause the setting to have more than four (4) people in the home.

Respite can be utilized on hourly or daily basis. Billing for hourly respite on the same day cannot exceed the reimbursement rate for daily respite.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the District that is not a private residence. Respite hourly care is provided in the person's place of residence.

This service is necessary to prevent people served through the waiver from being institutionalized or sent to an out-of-District program.

Respite care will ensure that persons served through the waiver have access to community activities as delineated in the person's ISP. Community activities, including transportation to and from these activities, are included in the rate for Respite. These activities include ensuring school attendance, school activities, or other activities the person would receive if they were not in respite. These community activities would allow the person's routine to not be interrupted.

Respite is not available to persons receiving Supported Living, Host Home, or Residential Habilitation services.

Respite can be offered in a person's home or another residential setting that would meet the requirements of certifications issued by the Department on Disability Services (DDS); Supported Living Provider-not to exceed 3 people; Residential Habilitation Provider-not to exceed 4 people as currently approved; or Home Health Agency.

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

Limited to 720 hours or 30 days per individual, per calendar year. Services provided cannot exceed those authorized in the Plan of Care. Any request for hours in excess of 720 hours must have DDS approval with proper justification and documentation.

A written justification for an increase in hours shall be submitted with the ISP, and Plan of Care by the provider to DDS. The written justification must include a description of the temporary emergency; an explanation of why no other natural or community resource are available; an explanation of how the additional hours of respite services will support the person's habilitative needs; a revised copy of the ISP reflecting the increase in support needs is submitted to the Medicaid Waiver Supervisor or other Department on Disability Services Administration designated staff for review and authorization.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Respite Provider Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Respite Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by DDS as a Respite Provider Agency per Provider Certification Review Policy

Other Standard *(specify):*

Provider enrolled to provide services through DDS/DHCF and has a current Medicaid agreement.

For individual employees, the following requirements apply:
- Documentation that each employee is eighteen (18) years of age or older;
- Documentation that each employee was found acceptable by the individual;
- Documentation from a physician or other official that the employee is free from communicable disease as confirmed by a purified protein derivative of tuberculin (PPD) Skin Test in accordance with current Centers for Disease Control (CDC) guidelines;
- Record of completion of competency-based training in communication with people with intellectual disabilities;
- Record of completion of competency-based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030;
- A high school diploma or general equivalency development;
- Record of completion of competency-based training in emergency procedures;
- Certification in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDS-approved pre-service and in-service training in DDS policies and procedures;
- Training is needed to address the unique support needs of the individual as detailed in their Plan of Care; and
- Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), 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, $5 44-55 1 et seq.).

Sec. 12006 (a) of the 21st Century Cures Act mandates that states implement Electronic visit verification (EVV) system required for all Medicaid personal care services and home health care services under that require an in-home visit by a provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

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:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 3:	**Sub-Category 3:**
03 Supported Employment	03022 ongoing supported employment, group
Category 4:	**Sub-Category 4:**
03 Supported Employment	03030 career planning

Service Definition *(Scope):*

Individual Services are designed to provide opportunities for people with disabilities to obtain competitive work in an integrated work setting, or employment in an integrated work setting in which individuals are working toward competitive work, consistent with strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice. The level of employment participation may be full-time or part-time. These services and supports should be designed to support successful employment outcomes consistent with the individual's goals. Supported Employment services are also provided to people with ongoing support needs for whom competitive employment has not traditionally occurred. In addition to the need for an appropriate job match that meets the individual's skills and interests, individuals with the most significant disabilities may also need long term employment support to successfully maintain a job due to the ongoing nature of the individual's support needs, changes in life situations, or evolving and changing job responsibilities. Stabilization services are a component of Supported Employment Services and are ongoing services needed to support and maintain an individual in an integrated competitive employment site or customized home-based employment.

Supported Employment Individual Services is not intended for people working in mobile work crews of small groups of people with disabilities in the community, but may be appropriate for small group supported employment to the extent that the setting complies with the HCBS settings rule.

Supported Employment may include:
1. Vocational assessments: All vocational assessments, regardless of the individual's vocational placement, are conducted by supported employment providers;
2. Benefits counseling: Analysis and advice to help the person understand the potential impact of employment on his or her public benefits, including, but not limited to Supplemental Security Income, Medicaid, Social Security Disability Insurance, Medicare, and Food Stamps."
3. Individual placement: A supported employment placement strategy in which an employment specialist (job coach) places a individual into competitive employment through a job discovery process, provides training and support, and then gradually reduces time and assistance at the worksite;
4. Development and on-going support for micro-enterprises owned and operated by the individual. This assistance consists of:
 a. Assisting the individual to identify potential business opportunities;
 b. Assisting the individual in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business;

c. Identification of the supports that are necessary in order for the individual to operate the business; and,
d. Ongoing assistance, counseling and guidance once the business has been launched.

On-the-job coaching Supported Employment services may be provided in person, or through phone or other technological means (e.g., Skype, Facetime), where approved by the person and his or her support team and documented in the ISP.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

As part of the person-centered planning process, the support team must discuss and create an individualized plan in the event that technology failures occur.

Supported Employment Services provided via remote support:

This service may be rendered using remote support. The purpose of the remote support delivery option is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and promote their ability to live independently, and meaningfully participate in their community. The participant's services may not be delivered virtually one hundred (100) percent of the time. The participant must always have the option to utilize in-person services. A participant who requires in-person assistance during the provision of the service must receive services in person. The use of the remote delivery service option is not for the convenience of providers.

Requirements and methodology regarding HIPAA have been approved by the DC HIPAA Compliance Officer. Participant privacy rights will be assured and monitored on an ongoing basis. Privacy obligations will be reviewed on an ongoing basis with providers and the person receiving services. Training will be provided for participants on how to identify or report issues if they believe their privacy has been violated. Providers will not use video or remote support devices in participant bedrooms or bathrooms. The use of the virtual support option must not block, prohibit or discourage the use of in-person services or access to the community. Community integration will be increased by having the option for remote service delivery. In instances where participants may not be inclined to attend or receive a service in-person, the remote service delivery option affords the opportunity for the participant to still participate in services, engage with their providers, community and friends, when they otherwise would not be able to do so due to illness, transportation issues, pandemics, or other personal reasons.

Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the remote delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The Individual Service Plan (ISP) must include a justification statement explaining how remote support assures health and safety If it is determined that in-person assistance is required, virtual support may not be provided.

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

Supported employment individual services:
Are not provided in specialized facilities that are not a part of the general workplace;
1. DO NOT include volunteer work; (volunteer learning and training activities that prepare a person for entry into the paid workforce are addressed through Employment Readiness services); and
2. DO NOT include payment for supervision; training; or support and adaptations typically available to other workers without disabilities filling similar positions in the business.

Day Habilitation, Employment Readiness, In-Home Supports, and Individualized Day Supports shall not be used at the same time as this service.

When Supported Employment services are provided at a work site in which persons without disabilities are employees, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Services are not available to people who can be fully supported individuals who are eligible to participate in programs

funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401 (16) and (71), but may be used to wrap around those programs.

Service Limits
1. Intake and Assessment activities shall not exceed 80 hours per calendar year.
2. Job Preparation, Development and Placement activities shall not exceed 240 hours per job placement per calendar year. Additional hours may be provided as prior authorized by DDS.
3. On the Job training shall not exceed more than 360 hours per placement per year. Additional hours may be provided as prior authorized by DDS.
4. This service is delivered no more than 40 hours per week, in combination with any other waiver day or vocational support services. This includes Day Habilitation, Small Group Supported Employment, Employment Readiness, or Individualized Day Supports.

Supported employment services is delivered no more than forty (40) hours per week in combination with any other Waiver day or vocational support services. This includes Day Habilitation, Employment Readiness, and Individualized Day Supports.

The supported employment service includes transportation furnished by the provider during the course of the service. Time spent in transportation to and from the program shall not be included in the total amount of services provided per day.

While the State Plan includes a transportation benefit, and providers under that benefit are capable of transporting IDD Waiver persons, this benefit is only used by IDD waiver persons to reach the supported employment site. This is because the State Plan transportation benefit cannot provide real-time services dedicated to a particular provider's needs. State Plan transportation services are coordinated by a non-emergency medical transportation broker. The service must be reserved in advance, and trips often include other non-IDD waiver persons on their way to a variety of destinations. As a result, it is not practical for a person to rely on transportation arranged by the broker during an episode of a supported employment service. The supported employment service covers such transportation, and it is separate and distinct from the State Plan transportation service generally.

The IDT will need to assess the person's ability to benefit from remote services engagement to determine how many hours the person can engage in remote supports for supported employment. Supported Employment services can be implemented partially in-person and partially remote supports.

Services cannot be delivered remotely one hundred (100) percent of the time.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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	Supported Employment Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Supported Employment Provider

Provider Qualifications

License *(specify):*

Chapter 9 of Title 29 of the District of Columbia Municipal Regulations

Certificate *(specify):*

DDS Provider Certification Review per DDS Policy.

Certified Enabling Technology Integration Specialist (ETIS) employed by a DDS Service Provider. Shift is the developmental and disability services industry's first online learning curriculum and community that standardizes best practices in Technology First programming. The program is accredited by the National Association of Direct Support Professionals. Currently, it includes two (2) programs:

1. Enabling Technology Integration Specialist Certification that provides specialized training in person-centered technology assessment and implementation; and

2. Technology First Accreditation for organizations demonstrating sustainable and standardized best practices in enabling technology integration

Other Standard *(specify):*

Provider enrolled to provide services through DDS/DHCF and has a current Medicaid agreement.
The provider must be enrolled as a provider for Rehabilitation Services Administration (RSA) within one year of becoming a supported employment provider. Owner-operators shall complete training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics determined by DDS, and in accordance with DDS published guidance within one year from the date the waiver application becomes effective for current providers and prior to any new waiver provider becoming approved to initiate services.

Documentation that each employee is eighteen (18) years of age or older;
- Documentation that each employee was found acceptable by the individual
- Annual documentation from a physician or other official that the employees are free from communicable diseases as confirmed by an annual purified protein as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test;
- Record of completion of competency-based training in communication with people with intellectual disabilities
- Record of completion of competency-based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030;
- A high school diploma or general equivalency development;
- Certification in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDC0approved pre-services and in-service training in DDS policies and procedures;
- Training is needed to address the unique support needs of the individual as detailed in their Plan of Care; and Verification of Provider Qualifications.

Within one year of becoming a supported employment provider:

The provider shall maintain evidence of completion of a professional development course that will satisfy a Basic Employment Certificate or comparable as required by the Association of Community Rehabilitation Educators (ACRE).

In addition to the requirements stated above, all staff working directly with persons with disabilities particularly in job development and placement , the following topic areas should be covered by the course or training and obtained within a year:
o Application of Core Values and Principles to Practice or Federal Policy and Historical Perspective required four (4) hours
o Individualized Assessment and Employment/ Career Planning or Customer Profile and Employment Selection required six (6) hours
o Community Research and Job Development or Organizational Marketing and Job Development required five (5) hours
o Workplace and Related Supports or Job-Site Training required ten (10) hours
o Others (Specific Disabilities, Long Term Support, Funding, Benefits Counseling etc.) required ten (10) hours

o The total hours of these services are forty (40) hours.

This training requirement may be waived if staff possesses a National Certificate in Employment Services or is a Certified Employment Support Professional".

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially, and annually thereafter

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:

Extended State Plan Service

Service Title:

Personal Care Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Personal care services are the performance of activities to assist persons with routine activities of daily living including bathing, toileting, transferring, dressing, grooming, eating, feeding self, and assisting with bowel and bladder control movements; or for safety monitoring.

Personal care services under the waiver shall only be provided when, after having fully utilized the daily limit of eight (8) hours of personal care services under the State Plan, a person needs additional hours per day of person care services. The scope and nature of personal care services under the waiver do not differ from those furnished under the State Plan. Likewise, the provider qualifications for personal care services specified in the State Plan also apply to waiver providers of personal care services. DDS maintains an updated list of all providers who are qualified and eligible for the provision of HCBS waiver services, including personal care services, which is accessible on DDS website and is also provided to persons

supported, their legal guardian, substitute decision-maker, and family members, as applicable.
Personal care services under the waiver are only provided to adults age 21 and over. All medically necessary personal care services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

- Personal care services and in-home supports may both be delivered on the same day, but cannot be delivered/billed at the same time.

- A person may receive personal care services at home, in the day setting, at school, at work, or in the community.

- Personal care services shall not be provided at the same time as residential habilitation, supported living, or host home services, except that a person may receive personal care services at school and at work.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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: Extended State Plan Service
Service Name: Personal Care Services

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Each Personal Care services provider shall:
Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for personal care services under the Waiver;

Maintain a copy of the plan of care approved by the Department of Department on Disability Services (DDS);

Ensure that all personal care services staff is qualified in accordance with Chapter 50 of Title 29 of the D.C.M.R. and properly supervised;

Complete required DDA HCBS Provider PHASE trainings. DDA PHASE trainings are training resources provided by the District and trainings conducted by professionals or nationally accredited institutions with expertise in providing certification on the subject matter;

Ensure that the service provided is consistent with the individual's plan of care;

Participate in the annual plan of care meeting or case conferences when indicated by DDS;

Offer the Hepatitis B vaccination to each person providing services pursuant to these rules;

Provide training in infection control procedures consistent with Occupational Safety and Health Administration (OSHA), US Department of Labor regulations 29 CFR 5 19 10.1030; and

Maintain a staff-to-individual ratio, indicated in the plan of care that ensures that the service meets the individual's individual needs, and that services are provided appropriately and safely.

Sec. 12006 (a) of the 21st Century Cures Act mandates that states implement Electronic visit verification (EVV) system required for all Medicaid personal care services and home health care services under that require an in-home visit by a provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS; Department of Health: Health Regulation Administration

Frequency of Verification:

Initially by DDS and annually thereafter; and on-going via DOH regulatory requirements.

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:

Extended State Plan Service

Service Title:

Skilled Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

- Skilled Nursing services are services listed in the Plan of Care/ISP that are within the scope of the District's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse licensed to practice in the District of Columbia.

- Persons served through the waiver must first utilize the full six (6) hours per day of skilled nursing services available under the State Plan prior to receiving additional hours of skilled nursing services under this waiver.

- Skilled Nursing services must be included in the person's Plan of Care/ISP, have a physician's order, a physician's letter of medical necessity, an individual nursing service plan, a summary of medical history, and the skilled nursing checklist.

- Skilled Nursing services also include consulting services (i.e. assessments and health related training and education for individuals and caregivers). These services may address healthcare needs related to prevention and primary care activities. Consultative services must be performed by a Registered Nurse.

- Skilled Nursing services may be delivered in the home or community, based upon where the services are needed, and subject to the following exclusions:
    * Skilled Nursing as an Extended State Plan service is only authorized for persons served through the waiver who live in Host Homes, Supported Living, independently, or in their natural homes.
    * Skilled nursing in Residential Habilitation and Supported Living with Skilled Nursing is accounted for in the rates for these services.
    * Skilled nursing as a separate waiver service is not authorized in residential habilitation and supported living with skilled nursing settings as a separate Extended State Plan Service.

- Edits for residential habilitation, and supported living with skilled nursing are in the MMIS system to ensure there is no duplication or overlap of skilled nursing services.

- This waiver service is only provided to adults age 21 and over. All medically necessary skilled nursing services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

- Skilled nursing services under the waiver may be available based on medical need for persons who, after having fully utilized the daily limit of six (6) hours of skilled nursing services under the State Plan, require additional hours per day of skilled nursing services to support living in the community (for persons who would otherwise be required to live in a nursing facility).

- One-to-one extended nursing daily limits may be increased to up to twenty-four (24) hours per day for persons on a ventilator or requiring frequent tracheal suctioning who have fully utilized the daily limit of six (6) hours of skilled nursing services under the State Plan. With prior approval, the annual limits may also be extended to up to 365 days per year for persons on a ventilator or requiring frequent tracheal suctioning who have exhausted the annual limits under the State Plan.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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: Extended State Plan Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Health-Care and Community Residence Facility Act, Hospice and Home-Care Licensure Act of 1983, effective Feb. 24, 1984 (DC Law 5-48; DC Official Code, § 44-501 et seq), and implementing rules.
A registered nurse licensed to practice nursing in accordance with the requirements of Chapter 54 of Title 17 of the D.C.M.R
An L.P.N. or Licensed Practical Nurse licensed to practice nursing in accordance with the requirements of Chapter 55 of Title 17 of the D.C.M.R

Certificate *(specify):*

Other Standard *(specify):*

Skilled Nursing services shall be provided by an RN or, a LPN under the supervision of an RN, or unlicensed trained personnel in accordance with the standards governing delegation of nursing interventions set forth in Chapters 54 and 55 of Title 17 DCMR.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS: Department of Health: Health Regulation and Licensing Administration

Frequency of Verification:

Initially by DSS and annually thereafter, and on-going via DOH regulatory requirements.

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:

Assistive Technology Services

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Assistive technology means an item, piece of equipment, service animal or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities and can also support increased community inclusion, including in employment settings. Assistive technology are devices/supports not otherwise available through any funding source that is suitable to enable the person to function with greater independence, avoid institutionalization and reduce the need for human assistance.

Assistive technology service means a service that directly assists a person in the selection, acquisition, or use of an assistive technology device. A person's need for assistive technology may be determined either by an assessment clinical evaluation or the recommendation of the person and/or the person's support team and incorporated into the person's ISP, where the recommendation is aimed at increasing the person's independence and/or community inclusion, including in an employment setting.

Assistive technology includes:
(A) the evaluation of assistive technology needs, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the person in his/her customary environment;
(B) services consisting of purchasing, leasing, subscribing to, or otherwise providing for the acquisition of assistive technology devices for persons served through the Waiver. Subscribing to assistive technology refers to a model where a person will pay a recurring fee (monthly, annually, etc.) to access assistive technology rather than purchasing it outright. This model allows for continuous improvements, updates, and maintenance without requiring full reinvestment in new devices or software;
(C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
(D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
(E) training or technical assistance for the person, or, where appropriate, his/her family members, guardians, advocates, or authorized representatives who provide unpaid support, training, companionship, or supervision;
(F) training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of the person served; and
(G) newer, more innovative technologies to ensure that the waiver keeps pace with advances in assistive devices and technologies that enhance independence and quality of life for people with disabilities in the IDD Waiver.
(H) Extension service for ongoing assistive technology services as necessary.

Allowable Assistive Technology items include:

1. Communication and Cognitive Aids: Tools and devices that assist with communication, memory, cognitive processing, or interaction with the environment. Examples: Speech-generating devices, speech-to-text tools, AI-powered voice assistants, text-to-speech software, augmented reality (AR) for cognitive training.

2. Environmental Control Systems: Devices that enable people to control their environment (home, work, etc.) independently. Examples: Smart home systems, voice-activated controls, IoT-enabled devices, motion-sensor appliances.

3. Health Monitoring and Management Devices: Tools that aid people in tracking, reporting, and managing their health or

daily wellness activities. Examples: Wearable health monitors, AI health analytics, automated medication dispensers, remote health management devices.

4. Navigation Aids: Equipment that assists with wayfinding in various environments, including GPS navigation devices or apps to assist people with wayfinding. Examples: wayfinding apps, wearables.

5. Sensory Enhancement and Adaptation Tools: Devices that enhance or compensate for sensory impairments (vision, hearing, etc.). Examples: Hearing aids, screen readers, AI vision aids (smart glasses for low vision), haptic feedback devices.

6. Remote Monitoring and Support Systems: Tools that allow for real-time remote support, monitoring, and communication. Examples: AI-powered remote support platforms, live video/audio feeds, sensor-based monitoring systems.

7. AI-Driven Predictive and Decision-Making Tools: Systems that use artificial intelligence to predict or recommend health, safety, or daily task decisions. Examples: AI algorithms for predicting health conditions, AI-based personal task assistants, decision-support systems.

8. Wearables and Personal Devices: Devices worn by people that enhance independence, health management, or communication. Examples: Smartwatches, fitness trackers, AR glasses, wearable health devices, tablets, smartphone.

9. Adaptive Learning and Personal Development Tools: Tools that facilitate learning, skill-building, and personal development through adaptive methods. Examples: Educational software, adaptive learning apps, virtual reality (VR) for skill-building.

10. Safety and Security Tools: Devices that ensure the safety and security of people in their home or community environments. Examples: Sensors, alarm devices or apps, seizure and elopement detection, kitchen safety devices, and home security systems.

11. Assistive Kitchen Devices: Devices and appliances that assist with meal preparation and ensure safety in the kitchen. Examples: Smart cooking appliances, automated stovetop safety devices, smart ovens.

To the extent that any listed services are covered under the state plan, including EPSDT, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

Assistive technology assessments may be conducted via telehealth. The following processes and protocols are maintained for remote/telehealth monitoring: (a) Responsible party & staffing location. Remote Support is delivered by a qualified Remote Support Professional (RSP) employed by the enrolled local provider or a subcontracted Remote Support Vendor (RSV). RSPs operate off-site from a secure monitoring center and respond during the authorized schedule in the person-centered plan. The local provider retains oversight and supplies the in-person backup responder staff. (b) Community integration. Remote Supports supplements, not replaces community participation and in-person support. It enables flexible, least-restrictive support so people can be at home or in the community with timely remote coaching, prompting, and problem-solving, reducing unnecessary staff presence and supporting employment, social, and independent living goals documented in the plan. (c) Privacy safeguards. The District prohibits continuous/live audio or video surveillance. Only user-activated or event-triggered technologies may be used, with minimum-necessary data collection. Providers must implement HIPAA-compliant safeguards (Agreement with RSVs, encryption, role-based access, audit logs) and follow DDS privacy/consent procedures. Roommate/household privacy is respected; only agreed-upon locations/devices are used. (d) Documented informed agreement. Prior to use, the participant (and involved family/guardian, when applicable) gives informed consent that is documented in the Individual Support Plan (ISP), including the devices to be used, when they are active, who may view data, and how to revoke/modify consent. In shared homes, all household members must consent to any devices placed in shared areas; dispute resolution steps are documented. (e) Health and welfare. The Remote Support Assessment and Plans for individuals shall specify protocols (e.g., call, video request, notify backup, dispatch 911), required response times, and escalation criteria to ensure needs are met and health/safety protected. Providers track alert response and outcomes, and the support team reviews data at least quarterly/six-monthly/annually to adjust supports. (f) Backup plan for equipment/technology failure. The Technology or Remote Support Plan is required to include descriptions of (1) in-person coverage if tech fails, (2) power/connection backup (e.g., battery, cellular failover), (3) notification procedures to the participant/guardian and team. (g) Device placement (bedrooms/bathrooms). Video cameras/continuous microphones are not permitted in any location, including bedrooms or bathrooms. Event-triggered non-video sensors (e.g., moisture, temperature, door, motion) may be used only as necessary and only where consented and documented in the plan. (h) Individualized necessity for any exceptional device. Not applicable, continuous video surveillance is prohibited. If any exceptional, non-

video sensor is proposed for a sensitive area due to compelling safety need, the rationale, safeguards, and consent(s) must be documented in the tech or remote support plan. (i) Participant control. The participant retains control over the technology, including the right to pause/decline user-activated sessions, request changes to monitoring hours, and withdraw consent at any time. Providers must train the participant on how to operate/disable user-activated devices and document this training and the "how to turn off" instructions in the plan. In-person backup response time. Providers must meet the District's 30-minute in-person response standard (as set in regulation) unless a shorter time is specified in the plan based on assessed need. Documentation & review. Providers maintain time-stamped alert/response logs and related documentation. The Support Team reviews implementation at least quarterly/annually and whenever there is a significant change, updating the plan as needed.

The support team planning process shall include clinicians whose specialty is in the area in which technologies are recommended. This is to ensure that appropriate assessments and technologies are per the person's identified clinical needs and increases the person's independence.

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

An individual receiving this service over the course of five years has a cap of $10,000.

An individual may be able to exceed this cap on a case-by-case basis with the approval of DDS; a prior authorization for the amount requested beyond the cap that includes supporting documentation; and is based on need.

Assistive technology provided through the waiver is over and above that which is available under the state plan, RSA, or that is the obligation of the individual's employer.

Assistive technology items under $1,000 do not require an assessment. A participant must have a technology plan, based on the person's support team's justification of need in the individual's support plan.

Persons enrolled in the IDD waiver between the ages of 18 and 21 years old, who need assistive technology for medical/health-related needs, should utilize Early Periodic Screening and Diagnostic Treatment (EPSDT) services under the Medicaid State Plan before accessing assistive technology under the waiver.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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	Licensed Therapists; AT Professionals
Agency	AT Professional Agency; Licensed Clinical Therapy Agency; AT Supplier

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology Services

Provider Category:

Individual

Provider Type:

Licensed Therapists; AT Professionals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

RESNA certified AT professionals

Certified Enabling Technology Integration Specialist (ETIS) employed by a Shift DDS Service Provider. Shift is the developmental and disability services industry's first online learning curriculum and community that standardizes best practices in Technology First programming. The program is accredited by the National Association of Direct Support Professionals. Currently, it includes two (2) programs:

1. Enabling Technology Integration Specialist Certification that provides specialized training in person-centered technology assessment and implementation; and

2. Technology First Accreditation for organizations demonstrating sustainable and standardized best practices in enabling technology integration.

Other Standard *(specify):*

Only professionals within a provider organization who are not licensed Assistive Technology Specialists, Occupational Therapists, Physical Therapists, or Speech, Hearing, and Language clinicians will be required to obtain certification through SHIFT's Enabling Technology Integration Specialist (ETIS) program to provide assistive technology services in the IDD Waiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and then annual thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology Services

Provider Category:

Agency

Provider Type:

AT Professional Agency; Licensed Clinical Therapy Agency; AT Supplier

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified Enabling Technology Integration Specialist (ETIS) employed by a Shift DDS Service Provider. Shift is the developmental and disability services industry's first online learning curriculum and community that standardizes best practices in Technology First programming. The program is accredited by the National Association of Direct Support Professionals. Currently, it includes two (2) programs:

1. Enabling Technology Integration Specialist Certification that provides specialized training in person-centered technology assessment and implementation; and

2. Technology First Accreditation for organizations demonstrating sustainable and standardized best practices in enabling technology integration.

Other Standard *(specify):*

Only professionals within a provider organization who are not licensed Assistive Technology Specialists, Occupational Therapists, Physical Therapists, or Speech, Hearing, and Language clinicians will be required to obtain certification through SHIFT's Enabling Technology Integration Specialist (ETIS) program to provide assistive technology services in the IDD Waiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

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:

Behavioral Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 3:	**Sub-Category 3:**
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Behavioral Support Services Tier One: Low Intensity Behavioral Support. This service provides up to 12 hours per year of behavioral support consultation and training for a person, his or her family, and/ or support team to provide technical assistance to address behaviors that interfere with a person's ability to achieve his or her ISP goals, but which are not dangerous, and to support skill building. Tier One Behavior Support Services may also be used to support a fade plan or develop a less restrictive option for any allowable modifications of the requirements of the HCBS Settings Rule (specifically Section 441.710, paragraphs (a)(1)(vi)(A) through (D)) that has been supported by a specific assessed need and justified in the person-centered service plan.

Behavior Support Services Tier Two: Moderate Behavioral Support. This service provides up to 50 hours per year (plus up to 26 hours of counseling services) for a participant who exhibits challenging behavior that either impacts a person's ability to retain a baseline level of independence (i.e. loss of job, loss of natural supports, eviction/ loss of residence, or causes a higher level of supervision than would otherwise be necessary); or that interferes with the person's quality of life (i.e. desired outcomes, relationships, exposure to and opportunities for engagement in a range of community activities).

Behavioral Support Services Tier Three: Intensive Behavioral Supports. Intensive Behavioral Support Services provides up to 100 hours per year (plus up to 52 hours of counseling service) to assist participants who exhibit behavior that is extremely challenging and frequently complicated by medical or mental health factors. This level of service is for a person who exhibits behaviors that, due to their frequency, severity, or intensity, pose a threat to the person's health or safety or to the health and safety of others. Behavior support services for a person in Tier three may incorporate one or more restrictive measures. Behavior Support techniques and interventions are designed to:

a. Decrease challenging behaviors while increasing positive alternative behaviors,
b. Assist participants in acquiring and maintaining the skills necessary to live independently in their communities, and
c. Avoid institutional placement.

To qualify for this service, each person must be referred by the Interdisciplinary Team (IDT). Behavioral Support Services are designed by a licensed professional or behavior management specialist supervised by a licensed professional.

Behavioral support services may include:
Assessment and evaluation of the person's behavioral need(s);
Development of a behavior support plan that includes intervention techniques for increasing adaptive positive behaviors, and decreasing maladaptive behaviors;
Provision of training for the individual's family and other support providers to appropriately implement the behavior support plan;
Evaluation of the effectiveness of the behavior support plan by monitoring the plan on at least a monthly basis. The service will also include needed modifications to the plan; and
The provider shall be available and responsive to the team for questions and consultation.
Training to create positive environments and coping mechanisms, as well as developing interventions, teamwork, and evaluation strategies to assess the effectiveness of interventions;
Consultative services to assist in the development of person-specific strategies and
Follow-up services, including personal progress assessment.

Components of Behavioral Support Services

To be eligible for behavioral support services, the provider shall develop a Diagnostic Assessment that is a clinical and functional evaluation of a person's psychological and behavioral condition. Based on this evaluation, the provider shall develop a Diagnostic Assessment Report. The Diagnostic Assessments shall determine whether the person may benefit from a Behavioral Support Plan (BSP), based on the person's presenting problems and behavioral goals. The Diagnostic Assessments shall also evaluate the person's level of readiness and motivation to respond to behavioral interventions. The DAR must be requested as a service in the ISP. All Behavioral Support Services must be in accordance with the recommendations made by the DAR within the past 36 months.

The Behavioral Support Plan (BSP) identifies strategies and services necessary to support and encourage the person in his or her decision to reside within the community; decrease the impact of a behavioral event; to assist the person in developing alternative and more effective communication, adaptive and coping mechanisms; and enable the person to achieve positive personal outcomes. The BSP is based on an understanding that there are reasons for challenging behaviors and those in a person's life must work to understand the underlying reasons. Therefore, BSPs must be based on a thorough and thoughtful functional assessment that results in a BSP with steps and methods to help the individual address his/her challenging behaviors and to assist the person with the development of positive behaviors as a replacement for challenging behaviors.

To the extent that any listed services are covered under the state plan, including EPSDT, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

Behavioral Supports Services provided via telehealth:

This service may be rendered using telehealth services. The purpose of the telehealth services delivery option is to address a

person's assessed professional, clinical, wellness, and therapeutic needs and promote autonomy, maintain or improve health outcomes, and promote real-time assessment, while the person is in the community. The participant's services may not be delivered virtually one hundred (100) percent of the time. The participant must always have the option to utilize in-person services. A participant who requires in-person assistance during the provision of the service must receive services in person. The use of the telehealth services delivery option is not for the convenience of providers.

Requirements and methodology regarding HIPAA have been approved by the DC HIPAA Compliance Officer. Participant privacy rights will be assured and monitored on an ongoing basis. Privacy obligations will be reviewed on an ongoing basis with providers and the person receiving services. Training will be provided for participants on how to identify or report issues if they believe their privacy has been violated. Providers will not use video or remote support devices in participant bedrooms or bathrooms. The use of the virtual support option must not block, prohibit or discourage the use of in-person services or access to the community. Community integration will be increased by having the option for remote service delivery. In instances where participants may not be inclined to attend or receive a service in-person, the remote service delivery option affords the opportunity for the participant to still participate in services, engage with their providers, community and friends, when they otherwise would not be able to do so due to illness, transportation issues, pandemics, or other personal reasons.

Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the telehealth delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The Individual Support Plan (ISP) must include a justification statement explaining how telehealth support assures health and safety of the individual. If it is determined that in-person assistance is required, virtual support may not be provided.

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

The person must be referred by the ISP Team or physician to address specific behavioral support needs that jeopardize the individual's health and welfare, and/or interfere with the individual's ability to gain independent living skills to qualify for this service and the service must be authorized in the Plan of Care.

Diagnostic assessments are limited to one (1) assessment every three (3) years unless approved for additional diagnostic assessments by the DDA Behavioral Health Officer, for example because the person changes providers.

The following usual and customary annual limits will be in place unless additional hours are approved by DDA Behavioral Health Officer. Any service billed by licensed (professional) staff must be undertaken and completed by licensed staff. Behavior support services by non-professional staff must be reviewed and approved by licensed or unlicensed staff. Behavioral support services by non-professional staff shall be provided by an intensive behavioral support direct care staff to one person exclusively by a behavior support service provider who has been trained in all general requirements. The non-professional staff must possess specialized training in physical management techniques and positive behavioral support practices, and who possess all other training required to implement the person's specific BSP, including behavioral and /or clinical protocols for a pre-authorized length of time.

The following are services available under Tier 2 behavioral supports (up to 50 hours per year with up to 26 additional hours for counseling):

Development of a new BSP;

Review and updating of existing BSP;

Training for the person, person's family, residential and day staff, and support team;

On-site consultation and observation;

Participation in behavioral review meetings or support team meetings;

Quarterly reports and monthly data monitoring;

Participation in psychotropic medication review meetings; and Counseling hours.

The following are services available under Tier 3 behavioral supports (up to 100 hours per year with up to 52 additional hours for counseling):

Development of a new BSP;

Review and updating of existing BSP;

Training for the person, person's family, residential and day staff, and support team;

On-site consultation and observation;

Participation in behavioral review meetings or support team meetings;

Quarterly reports and monthly data monitoring
Participation in psychotropic medication review meetings; and Counseling hours.

The IDT will need to assess the person's ability to benefit from remote services engagement to determine how many hours the person can engage in remote supports for behavior supports.

Services cannot be delivered via telehealth one hundred (100) percent of the time.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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	**Behavior Specialist**
Agency	**Home Care Agency**
Individual	**Licensed Graduate Social Worker**
Agency	**Mental Health Core Service Agency**
Individual	**Psychiatrist**
Individual	**Licensed Professional Counselor**
Individual	**Psychologist**
Individual	**Licensed Clinical Social Worker**
Individual	**Advance Practice Registered Nurse**
Individual	**Licensed Professional Art Therapist (LPAT) to provide paraprofessional behavioral support services.**

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Supports

Provider Category:
Individual
Provider Type:
Behavior Specialist

Provider Qualifications

License *(specify):*

District of Columbia Municipal Regulation Title 17, Chapter 69/ Section 6911/
Psychology.

Certificate *(specify):*

Certificate from the Behavioral Analyst Certification Board (BCBA), in the jurisdiction where the credential is accepted.

Other Standard *(specify):*

Minimum qualifications for behavior specialist in consultation includes Masters level psychologist, advanced practice nurse, LICSW, LGSW, licensed professional counselor or closely related field, and at least one year of experience serving people with developmental disabilities is required. Knowledge and experience in behavioral analysis is preferred.

Verification of Provider Qualifications

Entity Responsible for Verification:

The District's Department of Disability Services (DDS) is responsible for verification of each behavior specialist.

Frequency of Verification:

The frequency of verification for the behavior specialist is initial and then annually (every twelve months) thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Supports

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Supports

Provider Category:

Individual

Provider Type:

Licensed Graduate Social Worker

Provider Qualifications

License *(specify):*

DCMR Title 17, Chapter 70/Social Worker

Certificate *(specify):*

Other Standard *(specify):*

Minimum qualifications to draft positive behavior plan is Masters degree in psychology when supervised by a licensed psychologist or a licensed clinical social worker. Minimum qualifications for consultation are Masters level psychologist, advanced practice nurse, LCSW, LGSW and licensed professional counselor or closely related field, and at least one year of experience serving people with developmental disabilities. Knowledge and experience in behavioral analysis is preferred.In order to receive Medicaid reimbursement, a LGSW may provide counseling under the supervision of an LICSW or a LISW in accordance with the requirements set forth in Section 3413 of Chapter 34 of Title 22 of the DCMR.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Supports

Provider Category:

Agency

Provider Type:

Mental Health Core Service Agency

Provider Qualifications

License *(specify):*

Mental Health License as individual LICSW or LGSW, Psychologist or Psychiatrist

Certificate *(specify):*

Each Mental Health Core services agency must be a community-based provider of mental health services and mental health supports that is certified by the DC Department of Mental Health as a MH Core Service Agency. In addition, the service agency must act as a clinical home for consumers of mental health services by providing a single point of access and accountability for diagnostic assessment, medication-somatic treatment, counseling and psychotherapy, community support services, and access to other needed services.

Other Standard *(specify):*

Each Mental Health Core Service Agency must have a Certificate of Need or letter of exemption as well as DC Certificate of Occupancy.

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification is done by DC Department of Mental Health. DDS obtains verification of enrollment.

Frequency of Verification:

Initially by DDS, and annually or once every 12 months.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Supports

Provider Category:

Individual

Provider Type:

Psychiatrist

Provider Qualifications

License *(specify):*

§ 302(14) of the District of Columbia Health Occupations Revision Act of 1985, D.C. Law 6-99, D.C. Code § 2-3303.2(14) (1981 Ed.); and Mayors Order 86-110, dated July 18, 1986

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Supports

Provider Category:

Individual

Provider Type:

Licensed Professional Counselor

Provider Qualifications

License *(specify):*

DCMR Title 17, Chapter 66/Professional Counselor Certificate

Certificate *(specify):*

Other Standard *(specify):*

The minimum qualifications to draft a positive behavior plan are a Masters degree in psychology when supervised by a licensed psychologist or a licensed clinical social worker.

The minimum qualifications for consultation are Masters level psychologist, advanced practice nurse, LCSW, LGSW and licensed professional counselor or closely related field, and at least one year of experience serving people with developmental disabilities. Knowledge and experience in behavioral analysis is preferred.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Supports

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

District of Columbia Municipal Regulation Title 17, Chapter 69/ Psychology

Certificate *(specify):*

Other Standard *(specify):*

The minimum qualifications to draft a positive behavior plan are a Masters degree in psychology when supervised by a licensed psychologist or a licensed clinical social worker. The minimum qualifications for consultation are Masters level psychologist, advanced practice nurse, LCSW, LGSW and licensed professional counselor or closely related field, and at least one year of experience serving people with developmental disabilities. Knowledge and experience in behavioral analysis is preferred.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Supports

Provider Category:

Individual

Provider Type:

Licensed Clinical Social Worker

Provider Qualifications

License *(specify):*

DCMR Title 17, Chapter 70/Social Worker

Certificate *(specify):*

DCMR Title 17, Chapter 70/Social Worker

Other Standard *(specify):*

The minimum qualifications to draft a positive behavior plan are a Master's degree in psychology when supervised by a licensed psychologist or a licensed clinical social worker. Minimum qualifications for consultation are Master's level psychologist, advanced practice nurse, LCSW, LGSW, licensed professional counselor or closely related field, and at least one year experience serving people with developmental disabilities. Knowledge and experience in behavioral analysis is preferred.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Supports

Provider Category:

Individual

Provider Type:

Advance Practice Registered Nurse

Provider Qualifications

License *(specify):*

Advance Practice Registered Nurse (APRN) or Nurse-Practitioner (NP) pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1202 et seq.), or licensed as a registered nurse, APRN or NP in the jurisdiction where the services are being provided

Certificate *(specify):*

Other Standard *(specify):*

Minimum qualifications to draft positive behavior plan is master's degree in psychology when supervised by a licensed psychologist or a licensed clinical social worker. Minimum qualifications for consultation are Master's level psychologist, advanced practice nurse, LCSW, LGSW and licensed professional counselor or closely related field, and at least one year of experience serving people with developmental disabilities. Advanced practice registered nurses shall also have a specialty in a behavioral health field. Knowledge and experience in behavioral analysis is preferred. In order to receive Medicaid reimbursement, a LGSW may provide counseling under the supervision of an LICSW or a LISW in accordance with the requirements set forth in Section 3413 of Chapter 34 of Title 22 of the DCMR.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavioral Supports

Provider Category:

Individual

Provider Type:

Licensed Professional Art Therapist (LPAT) to provide paraprofessional behavioral support services.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

LPAT

Other Standard *(specify):*

May provide paraprofessional behavioral support services.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter.

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:

Companion Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Companion services are non-medical assistance and supervision provided in accordance with a person centered Plan of Care. The goal may be related to the person's safety, promotion of independence, community integration, and/or retirement. Companion services can be used during the day or overnight hours when supervision or non-medical support is needed to ensure the person's safety.

Companion services provide non-medical assistance and supervision to support a person's goals, desires, and needs as identified in the person's Individual Support Plan (ISP), and reflected in his or her Person-Centered Thinking and Discovery tools. Goals may be related to the person's safety, promotion of independence, community integration, and/or retirement. The provider must use the DDS-approved Person-Centered Thinking and Discovery tools to develop a support plan, based upon what has been identified as important to and for the person. For people who receive companion services during waking hours, this should include a flexible list of proposed leisure and recreational activities at home and in the community, based upon the person's interests.

Companion services cannot be provided at the same time as In-Home Supports, Periodic Supported Living, Personal Care Services, Respite, Host Home, and/or Behavioral Supports Non-Professional. Companion services may be provided outside of regular Monday to Friday daytime hours when supervision or other non-medical support is necessary to ensure the person's safety; provided, however, that companion services may not be used outside of regular Monday to Friday daytime hours in combination with Residential Habilitation or 24-Hour Supported Living or 24-Hour Supported Living with Transportation Services. Additionally, companion services may not exceed forty (40) hours per week when used with Residential Habilitation, 24-Hour Supported Living, and 24-Hour Supported Living with Transportation Services, or when used in combination with Personal Care Services or any other Waiver day or vocational support services, including but not limited to Day Habilitation, Employment Readiness, Supported Employment, Small Group Supported Employment, or Individualized Day Supports as part of a person's traditional Monday to Friday day/vocational programming time.

Companion services are available both as a one-to-one (1:1) service for a person and in small group settings not to exceed one-to-three (1:3). A waiver participant may utilize both one-to-one and small group companion services. Companion services are available as one-to-two (1:2) ratio for persons residing in HCBS waiver residential settings (e.g., Supported Living and Residential Habilitation) who require the appropriate staffing ratio to meet their needs during the day.

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

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

Companion services may be paired with In-Home Supports, Periodic Supported Living, and/or Personal Care Services at any time during the 24 hour day. It cannot be provided at the same time as In-Home Supports, Periodic Supported Living, Personal Care Services, Respite, Host Home, and/or Behavioral Supports Non-Professional. Edits for companion services shall be in the Medicaid Management Information system (MMIS) to ensure that there is no duplication or overlap of similar services provided by In-Home Supports, periodic supported living and personal care services.

Companion services can be used with Residential Habilitation and 24 hour Supported Living services, but only during regular daytime Monday - Friday hours, and may not exceed more than 40 hours per week, in combination with Personal Care Services or any other waiver day or vocational support services. This includes Day Habilitation, Employment Readiness, Supported Employment, Small Group Supported Employment, or Individualized Day Supports.

This service may be provided in the person's home or in the community. The companion 1:2 ratio is not applicable to persons receiving Supported Living staffing only supports in the natural home setting.

The unit of service shall be fifteen (15) minutes of Companion Service provided to the person. The number of units per visit must be indicated on the Plan of Care and the Service Authorization Form. The maximum number of units that can be authorized may not exceed eight (8) hours daily. The amount of time authorized does not include the Companion Worker's transportation time to or from the person's home; or the Companion Worker's break or mealtime.

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

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

☑ **Provider managed**

☐ **Remote/via Telehealth**

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	Companion Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion Services

Provider Category:

Agency

Provider Type:

Companion Provider Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Certified by DDS as a Companion Provider Agency per Provider Certification Review Policy

Other Standard *(specify):*

Provider enrolled to provide services through DDS/DHCF and has current Medicaid agreement.
For individual employees, the following requirements apply:
- Documentation that each employee is eighteen (18) years of age or older;
- Documentation that each employee was found acceptable by the individual;
- Annual documentation from a physician or other official that the employee is free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test;
- Record of completion of competency-based training in communication with people with intellectual disabilities;
- Record of completion of competency-based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030;
- A high school diploma or general equivalency development;
- Record of completion of competency-based training in emergency procedures;
- Certification in cardiopulmonary resuscitation (CPR) and First Aid;
- Training needed to address the unique support needs of the individual as detailed in their Plan of Care; and
- Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12- 238), 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, $5 44-55 1 et seq.).

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and Annually Thereafter

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:

Creative Arts Therapies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

The goal of Creative Arts Therapies services (part of "Professional Services" in the currently approved waiver) is to provide therapeutic supports to help a person with disabilities to express and understand emotions through artistic expression and through the creative process. Through these therapeutic services and processes, people can increase awareness of self and others, cope with symptoms of stress and traumatic experiences, enhance cognitive abilities, and enjoy the life-affirming pleasures of engaging in these types of therapies. Creative Arts Therapies can also assist with social and emotional difficulties related to a number of mental health issues including disability, illness, trauma and loss, physical and cognitive problems. Family and relationship issues such as abuse and domestic violence can also be treated with Creative Arts Therapies. The goal of Creative Arts Therapies is to assess and treat a variety of mental health problems including anxiety, depression, substance abuse, and or other addictions. The art therapist contributes consultative services and recommendations to the ISP to assist the team in determining service utilization.
Creative Arts Therapy services include:
Art Therapy
Dance Therapy
Drama Therapy
Music Therapy

Creative Arts Therapies may be utilized to: Assist in increasing the person's independence, participation, emotional well-being and productivity in their home, work and community; provide training or therapy to a person and/or their natural and formal supports necessary to developing critical skills that may be self-managed by the person or maintaining the person's skills; perform assessments and/or re-assessments and recommendations; provide consultative services and recommendations specific to the expert content; and provide necessary information to the person, family, caregivers, and/or team to assist in planning and implementing plans per the approved ISP/Plan of Care. Creative Arts Therapies services are available both as a one-to-one service for a person and in small-group settings, not to exceed 1:4. A waiver participant may utilize both one-to-one and small group Creative Arts Therapies.

Creative Arts Therapies Services provided via telehealth support:

This service may be rendered using telehealth support. The purpose of the telehealth support delivery option is to address a person's assessed professional, clinical, wellness, and therapeutic needs and promote autonomy, maintain or improve health outcomes, and promote hands on assessment while the person is in the community. The participant's services may not be delivered virtually one hundred (100) percent of the time. The participant must always have the option to utilize in-person services. A participant who requires in-person assistance during the provision of the service must receive services in person. The use of the telehealth delivery service option is not for the convenience of providers.

Requirements and methodology regarding HIPAA have been approved by the DC HIPAA Compliance Officer. Participant privacy rights will be assured and monitored on an ongoing basis. Privacy obligations will be reviewed on an ongoing basis with providers and the person receiving services. Training will be provided for participants on how to identify or report issues if they believe their privacy has been violated. Providers will not use video or telehealth support devices in participant bedrooms or bathrooms. The use of the virtual support option must not block, prohibit or discourage the use of in-person services or access to the community. Community integration will be increased by having the option for telehealth service delivery. In instances where participants may not be inclined to attend or receive a service in-person, the telehealth service delivery option affords the opportunity for the participant to still participate in services, engage with their providers, community and friends, when they otherwise would not be able to do so due to illness, transportation issues, pandemics, or other personal reasons.

Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the telehealth delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The Individual Support Plan (ISP) must include a justification statement explaining how telehealth support assures health and safety of the individual. If it is determined that in-person assistance is required, virtual support may not be provided.

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

The IDT will need to assess the person's ability to benefit from telehealth services engagement to determine how many hours the person can engage in telehealth support for creative art therapies. Creative art therapies services can be implemented partially in-person and partially telehealth supports.

Services cannot be delivered via telehealth one hundred (100) percent of the time.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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	Dance Therapist
Individual	Drama Therapist
Individual	Art Therapist
Individual	Music Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Creative Arts Therapies

Provider Category:

Individual

Provider Type:

Dance Therapist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Dance Therapists authorized to practice dance therapy in accordance with the registration requirements of Chapter 71 (Dance Therapy) of Subtitle: Health Occupations of Title 17 DCMR (Business, Industry, and Professions).

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially, and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Creative Arts Therapies

Provider Category:

Individual

Provider Type:

Drama Therapist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Drama Therapists certified by the National Association for Drama Therapy

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Creative Arts Therapies

Provider Category:

Individual

Provider Type:

Art Therapist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Art therapists certified to practice art therapy by the American Art Therapy Association, Inc.; Licensed Professional Art Therapist (LPAT).

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Creative Arts Therapies

Provider Category:

Individual

Provider Type:

Music Therapist

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Music Therapists certified by the Certification Board for Music Therapists (CBMT), managed by the American Music Therapy Association

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

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:

Dental

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11070 dental services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

The District of Columbia proposes to reimburse dental providers higher rates for providing dental services to IDD waiver enrollees than would be available under the State Plan. This is due to the higher oral health and behavioral needs of the IDD waiver enrollees, and to the additional resources required from participating dental providers to meet those needs. Individuals with IDD experience a higher prevalence of gingivitis, periodontal disease, tooth loss, and untreated dental caries than the general population due to challenges with oral hygiene and psychosocial factors in accessing routine dental care. Dental providers must commit greater attention and time for appointments, engage more auxiliary staff to provide supportive services during the appointments, provide accommodations beyond routine standard practices, and utilize behavior guidance techniques to deliver comprehensive oral health care to individuals with IDD. IDD Dental Providers are also required to use de-sensitization techniques prior to prescribing sedations for the procedures. They spend additional time training and educating the parent/caregiver in preventive oral health strategies and post-operative care to improve the oral health status of the IDD patient. As a result of the extensive needs of IDD waiver beneficiaries and the additional time, staff and other resources needed to treat these beneficiaries, the IDD waiver proposes a higher reimbursement rate. This higher level of services, coupled with the higher rate of payment, ensure that dental providers serving IDD waiver beneficiaries will be willing to treat and be able to meet the unique needs of the beneficiaries. In contrast, the State Plan does not provide reimbursement to the dental provider for ancillary and supportive services, parent/caregiver training, or any other additional resources needed to deliver comprehensive oral health care to individuals with IDD.

It is important to also note that not any FFS dental provider can treat IDD waiver beneficiaries and receive the enhanced payment. They must undergo an additional application process, in which they apply directly to DDS (not DHCF, as FFS dental providers do), agree to meet the terms and conditions of the waiver program, describe their experience treating the IDD population and their understanding of the population's special needs, and show how they will meet those needs during service delivery.

The Dental rate is an enhancement to the State Plan rate that was developed through a collaborative process that involved the state DD and Medicaid agencies, dental providers, the University Center for Excellence in Developmental Disabilities, and other stakeholders. It increases based upon market basket for nursing home and CPI inflation and has been sufficient to ensure adequate access to dental services for waiver participants. DDA regularly monitors to ensure all waiver participants have routine dental care and that any recommendations from the dentist are implemented. This is done through Service Coordination Monitoring as well as Health and Wellness monitoring. In the first quarter of FY 2017, over 95% of waiver participants have received all needed dental care.

To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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

This waiver service is only provided to adults age 21 and over. All medically necessary dental services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Dentist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dental

Provider Category:

Individual

Provider Type:

Dentist

Provider Qualifications

License *(specify):*

The provider must be a dentist licensed to practice dentistry in accordance with the requirements of Chapter 42 of Title 17 of the D.C.M.R.

Certificate *(specify):*

Other Standard *(specify):*

Providers must be enrolled as a dentist in the DC Medicaid program. In order to receive the enhanced payment rate, a dentist must also enroll and receive a separate I/DD provider number.Dentists must provide services consistent with the standards established by the American Dental Association.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially by DDS and through annual checks through DOH on continued licensure.

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:

Family Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to individuals persons served through the waiver. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion or co-worker, who provides uncompensated care, training, guidance, companionship or support to persons served through the waiver. Training includes instruction about treatment regimens and other services included in the plan of care and any other equipment specified in the plan of care, and includes updates as necessary to safely maintain the person at home and in the community. Counseling may be aimed at providing the person with peer supports training in service navigation, and any other training aimed at meeting the needs of the person served through the waiver. All training and counseling must be included in the individual's person's plan.

Family Training is available both as a one-to-one service for a person , and in small-group settings not to exceed 1:4. A person served through the waiver may utilize both one-to-one and small group Family Training services.

Family Training may be delivered by clinical professionals or by qualified peers, i.e., a qualified peer is an individual who meets the qualifications and standards as a family training provider.

Family Training peer services are arranged by DDS-certified provider organizations.

Family Training Services provided via telehealth support:

This service may be rendered using telehealth support. The purpose of the telehealth support delivery option is to assess professional, clinical, wellness, and therapeutic needs and promote autonomy, maintain or improve health outcomes, and promote real-time assessment while the person is in the community. The participant's services may not be delivered virtually one hundred (100) percent of the time. The participant must always have the option to utilize in-person services. A participant who requires in-person assistance during the provision of the service must receive services in person. The use of the telehealth delivery service option is not for the convenience of providers.

Requirements and methodology regarding HIPAA have been approved by the DC HIPAA Compliance Officer. Participant privacy rights will be assured and monitored on an ongoing basis. Privacy obligations will be reviewed on an ongoing basis with providers and the person receiving services. Training will be provided for participants on how to identify or report issues if they believe their privacy has been violated. Providers will not use video or telehealth support devices in participant bedrooms or bathrooms. The use of the virtual support option must not block, prohibit or discourage the use of in-person services or access to the community. Community integration will be increased by having the option for telehealth service delivery. In instances where participants may not be inclined to attend or receive a service in-person, the telehealth service delivery option affords the opportunity for the participant to still participate in services, engage with their providers, community and friends, when they otherwise would not be able to do so due to illness, transportation issues, pandemics, or other personal reasons.

Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the telehealth delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The Individual Support Plan (ISP) must include a justification statement explaining how telehealth support assures health and safety of the individual. If it is determined that in-person assistance is required, virtual support may not be provided.

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

Services are limited to 100 hours per year. Requests for additional hours may be approved by DDS, based upon the person's needs as documented in their ISP.

The IDT will need to assess the person's ability to benefit from the telehealth services engagement to determine how many hours the person can engage in remote support for family training. Family training services can be implemented partially in-person and partially telehealth supports.

Services cannot be delivered via telehealth one hundred (100) percent of the time.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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	Licensed Clinical Social Worker
Individual	Occupational Therapist
Agency	Home Care Agency
Individual	Licensed Graduate Social Worker
Individual	Physical Therapist
Individual	Speech/Language Therapist
Individual	Registered Nurse
Individual	Educator
Agency	Family Training Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training

Provider Category:

Individual

Provider Type:

Licensed Clinical Social Worker

Provider Qualifications

License *(specify):*

DCMR Title 17, Chapter 70/Social Worker

Certificate *(specify):*

Other Standard *(specify):*

Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), 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, $5 44-55 1 et seq.).

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially on enrollment and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

Title 17, DCMR, Chapter 63, Occupational Therapy

Certificate *(specify):*

Other Standard *(specify):*

Record of criminal background check consistent with the requirements of the health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), 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, $5 44-55 1 et seq.). Verification of Provider Qualifications

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially on enrollment and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Health-Care and Community Residence Facility Act, Hospice and Home-Care Licensure Act of 1983, effective Feb. 24, 1984 (DC Law 5-48; DC Official Code, § 44-501 et seq.), and District of Columbia Code, Title 2, Chapter 33, Sections 2.3301-2.3312 of the DC health Occupations Revision Act (Department of Consumer and Regulatory Affairs, Occupational and Professional Licensing Administration).

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS, DOH, HRLA

Frequency of Verification:

Initially on enrollment and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training

Provider Category:

Individual

Provider Type:

Licensed Graduate Social Worker

Provider Qualifications

License *(specify):*

DCMR Title 17, Chapter 70/Social Worker

Certificate *(specify):*

Other Standard *(specify):*

Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), 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, $5 44-55 1 et seq.).

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially on enrollment and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

Title 22 DCMR, Chapter 30

Certificate *(specify):*

Other Standard *(specify):*

Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), 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, $5 44-55 1 et seq.).

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially on enrollment and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training

Provider Category:

Individual

Provider Type:

Speech/Language Therapist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Accreditation by the American Speech-Language-Hearing Association.

Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), 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, $5 44-55 1 et seq.).

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially on enrollment and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Nurses are licensed under §302(14) of the District of Columbia Health Occupations Revision Act of 1985, D.C. Law 6-99,

D.C. Code §2-3303.2(14) (1988 Repl. Vol.), 33 DCR 729, 732 (February 7, 1986), and Mayors Order 86-110, 33 DCR 5220 (August 22, 1986)/ Title 17, Chapter 54 (Registered Nursing).

Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), 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, $5 44-55 1 et seq.).

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially on enrollment and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training

Provider Category:

Individual

Provider Type:

Educator

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Teachers Certification in DC, MD or VA.
Teachers must hold a Masters Degree in Special Education from an accredited college or university.

Other Standard *(specify):*

Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), 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, $5 44-55 1 et seq.).

Local IDD Waiver providers who have been certified to provide Remote Support Services can provide telehealth services. Providers furnishing Telehealth Services must meet the following requirements:
a. An individual or professional providing telehealth services shall meet all HCBS IFS waiver and state licensure or certification requirements to deliver waiver telehealth-based services, including but not limited to licensed behavioral health professionals, speech-language pathologists, occupational therapists, nutritionists, fitness trainers, registered nurses, social workers, and credentialed assistive technology specialists.
b. All Telehealth services must be delivered through a secure, HIPAA-compliant platform that supports real-time, two-way interactive audio and visual communication. The platform must ensure the confidentiality, integrity, and security of protected health information (PHI) in accordance with federal privacy regulations.
c. Telehealth services shall be provided in real time, not via a recording, by awake staff using the appropriate connection. While telehealth is being provided, the telehealth staff shall not have duties other than telehealth.
d. The Telehealth Provider shall provide initial and ongoing training to its staff to ensure the person knows how to use the technological equipment.
e. The Telehealth Provider shall provide an individual who receives telehealth services with initial and ongoing training on how to use the technology/equipment as specified in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially on enrollment and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training

Provider Category:

Agency

Provider Type:

Family Training Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DDS Provider Certification Review Certification, per DDS Provider Certification Review Policy and Procedures. For individual employees, the following requirements apply:

Lived experience as a family member of a person with intellectual disabilities;

Demonstrated history of advocacy either for themselves or their family members;

Documentation that each employee is 18 years of age or older;

Documentation that each employee was found acceptable by the individual;

A high school diploma or GED;

Annual documentation from a physician or other official that the employee is free from communicable disease as confirmed by an annual PPT skin test;and

Record of a criminal background check consistent with the requirements of the Health Care Facility Unlicensed Personnel Criminal Background Check Act of 1998

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially on enrollment and annually thereafter

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:

Health Assessment and Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11020 health assessment
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

The Health Assessment & Coordination (HAC) telehealth service is available to all IDD Waiver participants who choose the service. This standalone urgent care telehealth service will provide specific medical advice on when waiver participants should seek additional or in-person medical treatment via virtual applications and allow the provision of urgent care telehealth services. Health Assessment and Coordination (HAC) services act as a triage for individuals with IDD experiencing urgent or emergency clinical events, offering timely medical assessments to determine the best clinical course of action. By providing real-time advice and care coordination, these services help reduce unnecessary emergency room visits, prevent future hospitalizations, and support long-term health management. This service is designed to:

a) Assess and triage medical conditions to determine the most appropriate course of action, such as treating in place or transferring to a hospital.

b) Coordinate care with service providers, emergency departments, urgent care facilities, and primary care physicians.

c) Offer disability-specific medical advice tailored to the needs of individuals with IDD.

d) Prevent unnecessary emergency room visits and reduce hospitalization through proactive care and timely interventions.

e) Support people, service provider staff, caregivers and families by helping them understand symptoms and navigate healthcare decisions.

HAC services include:

1) Immediate evaluations;

2) Video-assisted examinations;

3) Prescription refills;

4) Treatment plans;

5) Triaging determination of whether to treat in place or transfer to a hospital;

6) Discussion and coordination with the person supported, service provider staff, and/or caregivers by professionals with extensive expertise in IDD; and

7) Follow-up care within 24 hours of the initial health assessment, if determined necessary, to provide additional guidance to the individual, provider staff, or caregiver.

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

A person may receive telehealth services in their home, and it acts as triage, but does not duplicate Medicaid services

covered under the State Plan.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**
- ☑ **Remote/via Telehealth**

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	Health Assessment and Coordination Services Provider as the Provider for the HAC service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Health Assessment and Coordination

Provider Category:

Agency

Provider Type:

Health Assessment and Coordination Services Provider as the Provider for the HAC service

Provider Qualifications

License *(specify):*

Licensed physician in the District of Columbia or have appropriate state reciprocity. Be licensed by the American Board of Medical Specialties (ABMS)

Certificate *(specify):*

Board certified or board eligible MD or DO.

Other Standard *(specify):*

Be employed by a Health Assessment and Coordination (HAC) service provider that has a current District of Columbia Medicaid Provider agreement, authorizing the service provider to bill for HAC services. Have completed specialized training/curriculum to care for people with Intellectual and Developmental Disabilities (IDD). The provider must have a minimum of four years' experience in serving individuals with intellectual and developmental disabilities in their own homes, family homes, host home, residential habilitation, and supported living residential settings, as well as other types of long-term supports and services. The provider must have demonstrated evidence of positive outcomes for individuals served. The provider must provide continuing education in the area of intellectual and developmental disabilities to the provider's physician network. The provider must meet technological and privacy requirements as set forth by the District. Prior to contract and at each contract renewal, the provider must submit to the District successful results from a self-assessment validating staff qualifications, required documentation, policies and procedures. The provider must have a participant support call center that is staffed 24 hours a day, 7 days a week. Provider has references related to the provider's business history and practices. The service provider must have a comprehensive quality review program and provide a report via secure e-mail of their aggregated findings at the end of each month, as well as one time annually, to the DDS, which must include, at a minimum, the following: a. Data analysis; b. Service outcomes; c. Individual, family and/or caregivers of individuals, and provider satisfaction; and d. Complaints and resolution.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter.

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:

Host Home

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Host Home services enable persons served through the waiver to retain or improve skills related to health, activities of daily living, money management, community mobility, recreation, cooking, shopping, use of community resources, community safety and other adaptive skills needed to live in and be a part of the community, based upon what is important to and for the person, as documented in his or her Individualized Support Plan (ISP) and reflected in his or her Person-Centered Thinking tools. Host Home services are provided in a private home by a principal care provider who lives in the home and either rents or owns the home. Host Home services are furnished to persons served through the waiver who require up to 24-hour services as determined by a District managed assessment process and ISP. Residential and community integration services are delivered in conjunction with residing in the home.

The total number of people (including those served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed three (3) persons.

Host Home services provide support to people who have limited informal supports and have an assessed need for assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed-making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the person to reside in and be a part of his or her community, based upon what is important to and for

the person, as documented in his/her ISP and reflected in his or her Person-Centered Thinking tools and who would benefit living in a family home.

Host Home services are provided by a person(s) unrelated to the person(s) served through the waiver by , or a family member, who is not a parent, spouse or legally responsible relative. The Host Home is responsible for participating in and abiding by the Plan of Care as well as maintaining records in accordance with State and provider requirements.

Host Home services are arranged by DDS certified provider organizations that operate residential programs. Host Homes are subject to standards identified by the District. All Host Homes Settings must fully comply with the requirements of the HCBS Settings Rule. The provider organization has 24-hour responsibility for arranging and overseeing the Host Home, conducting monthly visits to review the implementation of the ISP, ensuring adherence to DDS policy by the Host Home, providing emergency services as needed, providing in-home support services between 5 to 20 hours per week based on the level of Host Home services authorized to support the Host Home provider with habilitation and training activities, and providing or arranging for 14 days of Host Home Respite per year. The Host Home receives an initial inspection by the provider organization as well as periodic inspections with a frequency determined by the provider, but is not subject to licensure.

Waiver payments are not made for room and board.

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

For persons served through the waiver receiving Host Home services, separate payment will not be made for Respite since these services are integral to and inherent in the provision of Host Home services.

Host home without transportation services shall not be reimbursed by Medicaid if they are billed at the same time as the following IDD Waiver services are provided to the person: supported living, residential habilitation, personal care (unless provided when a person is working or in school), respite, and in-home supports. However, a person in host home may receive Personal Care Services if they are employed and/or in school.

The host home service includes transportation furnished by the provider during the course of the service. While the State Plan includes a transportation benefit, and providers under that benefit are capable of transporting IDD Waiver individuals, this benefit cannot not provide real-time services dedicated to a particular provider's needs. State Plan transportation services are coordinated by a non-emergency medical transportation broker. The service must be reserved in advance, and trips often include other non-IDD waiver beneficiaries on their way to a variety of destinations. As a result, it is not practical for a beneficiary to rely on transportation arranged by the broker while at a host home. The host home service covers such transportation, and it is separate and distinct from the State Plan transportation service generally.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Residential Habilitation Provider
Agency	Supported Living Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Host Home

Provider Category:

Agency

Provider Type:

Residential Habilitation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DDS Provider Certification Review per DDS Policy

Other Standard *(specify):*

Providers enrolled should provide services through DDS/DHCF, and have a current Medicaid agreement. In addition, they may be required to have a current Human Care Agreement with DDS for the provision of residential services.
Owner-operators shall complete training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics determined by DDS, and in accordance with DDS published guidance within one year from the date, the waiver application becomes effective for current providers and prior to any new waiver provider becoming approved to initiate services.

For individual employees, the following requirements apply:
- Documentation that each employee is eighteen (18) years of age or older;
- Documentation that each employee was found acceptable by the individual;
- Annual documentation from a physician or other official that the employee is free from all communicable diseases as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test;
- Record of completion of competency-based training in communication with people with intellectual disabilities;
- Record of completion of competency-based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor
regulations at 29 CFR 1910. 1030;
- A high school diploma or general equivalency development;
- Record of completion of competency-based training in emergency procedures;
- Certification (active) in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDS-approved pre-service and in-service training in DDS policies and procedures;
- Training is needed to address the unique support needs of the individual as detailed in their Plan of Care; and
- Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), 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, $5 44-55 1 et seq.).

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially, and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Host Home

Provider Category:

Agency

Provider Type:

Supported Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DDS Provider Certification Review per DDS Policy

Other Standard *(specify):*

The provider should be enrolled to provide services through DDS/DHCF and have a current Medicaid agreement. Also, they may be required to maintain a human care agreement with DDS for the provision of residential services. Owner-operators shall complete training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics determined by DDS, and in accordance with DDS published guidance within one year from the date, the waiver application becomes effective for current providers and prior to any new waiver provider becoming approved to initiate services.

For individual employees, the following requirements apply:

- Documentation that each employee is eighteen (18) years of age or older;
- Documentation that each employee was found acceptable by the individual;
- Annual documentation from a physician or other official that the employee is free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test;
- Record of completion of competency-based training in communication with people with intellectual disabilities;
- Record of completion of competency-based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030;
- A high school diploma or general equivalency development;
- Record of completion of competency-based training in emergency procedures;
- Certification (active) in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDS-approved pre-service and in-service training in DDS policies and procedures;
- Training is needed to address the unique support needs of the individual as detailed in their Plan of Care; and
- Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), 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, $5 44-55 1 et seq.).

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially, and annually thereafter

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:

Individualized Day Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Individualized Day Supports services provide habilitative services to persons served through the waiver in order to attain new and maintain existing skills based on individualized preferences and goals. The activities that the person engages in include formal strategies for teaching the individualized skills and the intended outcome for the individual. Services and supports are to prepare and support a person for community participation and/or meaningful retirement activities, employment discovery and/or exploration, and could not do so without this direct support. Individualized Day Supports are intended to be different and separate from residential services. Individualized Day Supports are designed to support the person, whenever possible, outside the home through training and skills development, which enable the person to experience greater participation in community integrated activities and move to the most integrated vocational setting appropriate to his or her needs. IDS provides persons served through the waiver with opportunities to engage in community based activities that support socialization, education, recreation and personal development for the purpose of: (1) Building and strengthening relationships with others in the local community who are not paid to be with the person; and (2) Learning, practicing and applying skills that promote greater independence and inclusion in their community. Personal care/assistance may be a component part of individualized day supports services as necessary to meet the needs of an individual, but may not comprise the entirety of the service. Supports and services may also be used to provide supported retirement activities. As people get older they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their communities. This might involve altering schedules to allow for more rest time throughout the day, support to participate in hobbies, clubs and/or other senior related activities in their communities, including attending integrated senior centers. Individualized Day Supports services shall focus on enabling the person to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the Person Centered Plan. Individualized Day Supports services are to meet the day programming needs of individuals who choose not to attend or receive services provided in a larger formal group setting, such as Day Habilitation. Community activities that originate from a facility based day setting can be provided and billed as Individualized Day Supports. On site attendance at the licensed setting is not required to receive services that originate from the setting.

Individualized Day Supports is a structured day activity based on the individualized approved ISP. The intent of this service is to support individuals who would benefit and thrive in an atmosphere that is customized to focus on specified goals and preferences for a specified amount of time (i.e., those that are transitioning into retirement; those with degenerative conditions; or those that choose to no longer attend setting based Day Habilitation programs) for the purpose of advancing community integration. The supports would include activities such as volunteer work (which focuses on goals/outcomes and is not based on recreational activities, and is focused on
community inclusion, community service, and general employment skills not specific to an employment goal), participating in Senior Centers, or working on adult skill development in natural community based settings, for example. Services and supports provided to individuals are tailored to their specific personal goals and outcomes related to the acquisition, improvement, and/or retention of skills. The services and supports consist of an integrated array of individually designed habilitation services and supports that are described in the approved ISP. For people who live in their own home or with

their family, IDS may include provision of a meal, including preparation, packaging, and delivery to the setting at which IDS is being provided, as needed. The provision of meals shall take place during typical lunchtime hours (11am-1pm). In order to receive this service, the person must be identified as having difficulty in shopping and/or preparing appropriate, nutritious meals. This meal shall be nutritionally adequate and prepared based on the person's specific needs as per the person's Level of Need, and, when necessary, the nutritionist/doctor's recommendation. This meal must meet one-third (1/3) of a person's Recommended Dietary Allowance (RDA) and must comprise of foods the person enjoys eating when not medically contraindicated.

Individualized Day Supports are available both as a one-to-one service for a person, and in small group settings not to exceed 1:2 based upon the person's assessed needs; and for limited times, as approved by DDS, based on the ability to match the participant with an appropriate peer to participate with for small group IDS. Individualized Day Supports will include a nutritionally adequate meal for participants who live independently or with their families and who select to receive a meal.

Individualized Day Supports may only be delivered in non-residential settings, separate from the participant's private or other residential living arrangement.

Individualized Day Support may not be used for education-related services as defined in Sections (22) and (25) of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) (20 U.S.C. 1401 et seq.) or services available under section 100 of the Rehabilitation A t of 1973. For people using IDS for educational purposes, documentation is maintained in the file of each person that the service is not otherwise available under section 110 of the Rehabilitation Act of 1973 or the IDEA.

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

This service shall be delivered in a variety of community settings that the individual chooses to attend for up to six (6) hours per day. IDS may be authorized for a minimum of 2 and a maximum of 6 hours per day. This service shall not provide reimbursement to Senior Centers funded by the federal Older Americans Act to provide services to older adults.

The individualized day supports service includes transportation furnished by the provider during the course of the service. While the State Plan includes a transportation benefit, and providers under that benefit are capable of transporting IDD Waiver individuals, this benefit is only used by IDD waiver beneficiaries to reach the individualized day supports site. This is because the State Plan transportation benefit cannot not provide real-time services dedicated to a particular provider's needs. State Plan transportation services are coordinated by a non-emergency medical transportation broker. The service must be reserved in advance, and trips often include other non-IDD waiver beneficiaries on their way to a variety of destinations. As a result, it is not practical for a beneficiary to rely on transportation arranged by the broker during an episode of an individualized day supports service. The individualized day supports service covers such transportation, and it is separate and distinct from the State Plan transportation service generally.

The Individualized Day Program does NOT include activities which are the responsibility of the Supported Living, Residential Supports, Host Home or In-Home Supports provider, such as cooking or laundry activities. This service is delivered for no more than 30 hours per week, and may be offered in combination with any other waiver day or vocational support services. In combination, the person may not receive more than 40 hours per week of waiver day or vocational support services. This includes Day Habilitation, Employment Readiness, Small Group Supported Employment, or Supported Employment.

A participant's individual service plan may include two or more types of non-residential habilitation services (e.g. Supported employment individual, Supported employment small group, Employment readiness services, Individualized Day Supports, Day habilitation); however, more than one service may not be billed during the same period of time (e.g. the same hour).

Meals provided as part of the Individualized Day Supports service shall not constitute a full daily nutritional regimen.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Individualized Day Supports

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individualized Day Supports

Provider Category:

Agency

Provider Type:

Individualized Day Supports

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DDS Provider Certification Review Certification, per DDS Provider Certification Review Policy and Procedures.

Other Standard *(specify):*

Each Individualized Day Support services provider shall be enrolled as a Qualified Provider of Individualized Day Support with DHCF, and hold a Medicaid Provider Agreement. Owner-operators shall complete training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics determined by DDS, and in accordance with DDS published guidance within one year from the date the waiver application becomes effective for current providers and prior to any new waiver provider becoming approved to initiate services.

For individual employees, the following requirements apply:

- Documentation that each employee is eighteen (18) years of age or older;
- Annual documentation from a physician or other official that the employee is free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test;
- Record of completion of competency-based training in communication with people with intellectual disabilities;
- Record of completion of competency-based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030.;
- A high school diploma or general equivalency development;
- Record of completion of competency-based training in emergency procedures;
- Certification in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDS-approved pre-service and in-service training in DDS policies and procedures;
- Record of completion of DDS-approved orientation for individual employees working in Individualized Day Supports. Training needed to address the unique support needs of the individual as detailed in their Individual Support Plan;
- Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), 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, $5 44-55 1 et seq.); and
- For individual employees supporting people in IDS at a 1:1 ratio, based upon the person's assessed needs, the employee must have at least one year experience (inclusive of lived experience and/ or volunteering) working with people with intellectual and developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially, and annually thereafter

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:

Occupational Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Occupational Therapy services are designed to maximize independence, prevent further disability, and maintain health. These services should be provided in accordance with the individual's Plan of Care. All Occupational Therapy services should be monitored to determine which services are most appropriate to enhance the individual's well-being and meet the therapeutic goals. This is not an extended state plan service. This service may be used in addition to or in place of the state plan service if indicated as needed by the physician. This service differs from the state plan service by provider qualifications and locations where the service may be delivered. The Occupational Therapist, under the HCBS waiver, is not restricted to those employed by hospitals or clinics. This service is delivered by a licensed practitioner and is delivered in the individual's home or day service setting.

Occupational Therapy Services provided via telehealth support:

This service may be rendered using telehealth support. The purpose of the remote support delivery option is to address a person's assessed professional, clinical, wellness, and therapeutic needs and promote autonomy, maintain or improve health outcomes, and promote real-time assessment while the person is in the community. The participant's services may not be delivered virtually one hundred (100) percent of the time. The participant must always have the option to utilize in-person services. A participant who requires in-person assistance during the provision of the service must receive services in person.

The use of the telehealth delivery service option is not for the convenience of providers.

Requirements and methodology regarding HIPAA have been approved by the DC HIPAA Compliance Officer. Participant privacy rights will be assured and monitored on an ongoing basis. Privacy obligations will be reviewed on an ongoing basis with providers and the person receiving services. Training will be provided for participants on how to identify or report issues if they believe their privacy has been violated. Providers will not use video or telehealth support devices in participant bedrooms or bathrooms. The use of the virtual support option must not block, prohibit or discourage the use of in-person services or access to the community. Community integration will be increased by having the option for telehealth service delivery. In instances where participants may not be inclined to attend or receive a service in-person, the telehealth service delivery option affords the opportunity for the participant to still participate in services, engage with their providers, community and friends, when they otherwise would not be able to do so due to illness, transportation issues, pandemics, or other personal reasons.

Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the telehealth delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The Individual Support Plan (ISP) must include a justification statement explaining how telehealth support assures health and safety of the individual. If it is determined that in-person assistance is required, virtual support may not be provided.

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

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

This waiver service is only provided to adults age 21 and over. All medically necessary occupational therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

The IDT will need to assess the person's ability to benefit from telehealth services engagement to determine how many hours the person can engage in telehealth supports for occupational therapy. Occupational Therapy services can be implemented partially in-person and partially telehealth supports.

Services cannot be delivered via telehealth one hundred (100) percent of the time.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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	Occupational Therapist
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

An Occupational Therapist licensed to practice occupational therapy in accordance with the requirements of Chapter 63 of Title 17 of the D.C.M.R

Certificate *(specify):*

Other Standard *(specify):*

Local IDD Waiver providers who have been certified to provide Remote Support Services can provide telehealth services. Providers furnishing Telehealth Services must meet the following requirements:
a. An individual or professional providing telehealth services shall meet all HCBS IFS waiver and state licensure or certification requirements to deliver waiver telehealth-based services, including but not limited to licensed behavioral health professionals, speech-language pathologists, occupational therapists, nutritionists, fitness trainers, registered nurses, social workers, and credentialed assistive technology specialists.
b. All Telehealth services must be delivered through a secure, HIPAA-compliant platform that supports real-time, two-way interactive audio and visual communication. The platform must ensure the confidentiality, integrity, and security of protected health information (PHI) in accordance with federal privacy regulations.
c. Telehealth services shall be provided in real time, not via a recording, by awake staff using the appropriate connection. While telehealth is being provided, the telehealth staff shall not have duties other than telehealth.
d. The Telehealth Provider shall provide initial and ongoing training to its staff to ensure the person knows how to use the technological equipment.
e. The Telehealth Provider shall provide an individual who receives telehealth services with initial and ongoing training on how to use the technology/equipment as specified in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS, Department of Health, HRLA

Frequency of Verification:

Initially and annually thereafter

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:

One-Time Transitional Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

One-Time Transitional Services are non-recurring set-up expenses for people who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for their own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that does not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings 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 person's health and safety such as pest eradication, including treatment for bedbugs, as necessary, and one-time cleaning prior to occupancy; (e) moving expenses; (f) Home accessibility adaptations and repairs such as carpeting, one-time general home repair, including roof

repair, painting and fence repair; and, (g) activities to assess need, arrange for and procure needed resources. One-Time Transitional Services are furnished only to the extent that they are reasonable and necessary as determined through the Plan of Care development process, clearly identified in the Plan of Care, and the person is unable to meet such expenses or the services cannot be obtained from other sources. One-Time Transitional Services do not include monthly rental or mortgage expenses; food; regular utility charges; and/or household appliances or items that are intended purely for recreational purposes; or any durable medical equipment. One-Time Transitional Services are a one-time, one-unit service. The unit should be noted as a service.

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

Medicaid reimbursement for OTT services shall be limited to a maximum dollar amount per person as a one-time, non-recurring expense. Service expenditures will be tracked by MMIS and DDS data files and through prior and post-authorization records.

One-time payment of $5000 per individual for the duration of the waiver period as a non-recurring expense. Service expenditures will be tracked by MMIS and DDS data files and through prior and post-authorization records.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Supported Living Provider
Agency	Residential Habilitation Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: One-Time Transitional Services

Provider Category:

Agency

Provider Type:

Supported Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider enrolled should provide Supported Living services through DDS/DHCF under the HCBS waiver via a Medicaid Provider Agreement, and possess a current Human Care Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: One-Time Transitional Services

Provider Category:

Agency

Provider Type:

Residential Habilitation Provider

Provider Qualifications

License *(specify):*

DCMR Chapter 35 licensure

Certificate *(specify):*

Other Standard *(specify):*

Enrolled as a Residential Habilitation provider through DDS/DHCF under the HCBS waiver with a current Medicaid Provider Agreement and DDS Human Care Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

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:

Parenting Supports

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Parenting Support assists people who are or will be parents in developing appropriate parenting skills. Parents will receive training that is individualized and focused on the health and welfare and developmental needs of their child, as well as building necessary parenting skills. Close coordination will be maintained with informal and other formal supports. This service is available to expectant parents, and parents with physical custody, visitation rights or parents who are pursuing reunification with their child.

This service may include training of individuals who provide unpaid support, training, companionship or supervision to persons served through the waiver to reinforce strategies provided to the person served.

Parenting Support services are available both as a 1:1 service and in a small group setting, not to exceed 1:4. This service shall be provided in the person's home or in a variety of community-based settings, based upon the person's needs and choices.

Parenting Support services do not include activities that are the responsibility of Supported Living, Supported Living with Transportation, Residential Habilitation, Host Home or In-Home Supports and can be offered in combination with any waiver residential services.

Parenting Supports Services provided via telehealth support:

This service may be rendered using telehealth support. The purpose of the telehealth support delivery option is to address a person's assessed professional, clinical, wellness, and therapeutic needs and promote autonomy, maintain or improve health outcomes, and promote real-time assessment while the person is in the community. The participant's services may not be delivered virtually one hundred (100) percent of the time. The participant must always have the option to utilize in-person services. A participant who requires in-person assistance during the provision of the service must receive services in person. The use of the telehealth delivery service option is not for the convenience of providers.

Requirements and methodology regarding HIPAA have been approved by the DC HIPAA Compliance Officer. Participant privacy rights will be assured and monitored on an ongoing basis. Privacy obligations will be reviewed on an ongoing basis with providers and the person receiving services. Training will be provided for participants on how to identify or report issues if they believe their privacy has been violated. Providers will not use video or telehealth support devices in participant bedrooms or bathrooms. The use of the virtual support option must not block, prohibit or discourage the use of in-person services or access to the community. Community integration will be increased by having the option for telehealth service delivery. In instances where participants may not be inclined to attend or receive a service in-person, the telehealth service delivery option affords the opportunity for the participant to still participate in services, engage with their providers, community and friends, when they otherwise would not be able to do so due to illness, transportation issues, pandemics, or other personal reasons.

Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the telehealth delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The Individual Support Plan (ISP) must include a justification statement explaining how telehealth support assures health and safety of the individual. If it is determined that in-person assistance is required, virtual support may not be provided.

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

Parenting Support is limited to 1460 hours per ISP year of individualized child-focused direct training per week. Support is available from the first trimester until the eligible participant's child transitions from high school.

The IDT will need to assess the person's ability to benefit from telehealth services engagement to determine how many hours the person can engage in telehealth supports for parenting supports. Parenting supports services can be implemented partially in-person and partially telehealth supports.

Services cannot be delivered via telehealth one hundred (100) percent of the time.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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	In Home Supports, Supported Living, Supported Living with Transportation, Host Home

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Parenting Supports

Provider Category:

Agency

Provider Type:

In Home Supports, Supported Living, Supported Living with Transportation, Host Home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider should be enrolled to provide services through DDS/ DHCF and have a current Medicaid agreement.

For professional employees, the following requirements apply:
Comply with the requirements of 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.); 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.)

Documented completion of any DDS-required training.

Masters degree in field related to supporting people with disabilities, including but not limited to: social services, education, psychology.

At least five years of experience working with people with intellectual disabilities and/ or their families.

Demonstrated ability, experience and education to: teach adult learners; conduct support needs assessments; implement service/ support plans; assist parent in specific areas of support described in the plan; serve as an advocate; work with people of varied ethnic and cultural backgrounds.

Ability to navigate through the various District of Columbia child-serving agencies and how to access the benefits and supports available to children in the District.

For peer employees, the following requirements apply:

At least eighteen (18) years of age.

Comply with the requirements of 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.); 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.)

Documented completion of any DDS-required training.

Documentation that the peer employee was found acceptable by the person.

Have lived experience as a parent with a disability or the parent/caregiver of a person with a disability that includes at least two of the following:

(1) Advocating on behalf of people with disabilities;
(2) Be trained in advocacy on behalf of people with disabilities by an advocacy organization;
(3) Be trained and certified in peer counseling by a certified peer counseling organization;
(4) Knowledge of the DC CFSA and DC DDA scope of services
(5) Skills in Engagement, Relationship Building, and Collaboration with Families and Caregivers
(6) Knowledge of Community Systems, Partnerships and Resources
(7) Ability to navigate through the various District of Columbia child-serving agencies and how to access the benefits and supports available to children in the District.

A peer employee may be the person's relative, but may not be legally responsible for the person, or the person's legal guardian.

A Peer Employee shall not perform parenting Support services with a person if he or she also provides the same person with the following IDD Waiver services: Residential Habilitation; Supported Living; Supported Living with Transportation; Host Home; or In-Home Supports.

Local IDD Waiver providers who have been certified to provide Remote Support Services can provide telehealth services. Providers furnishing Telehealth Services must meet the following requirements:

a. An individual or professional providing telehealth services shall meet all HCBS IFS waiver and state licensure or certification requirements to deliver waiver telehealth-based services, including but not limited to licensed behavioral health professionals, speech-language pathologists, occupational therapists, nutritionists, fitness trainers, registered nurses, social workers, and credentialed assistive technology specialists.
b. All Telehealth services must be delivered through a secure, HIPAA-compliant platform that supports real-time, two-way interactive audio and visual communication. The platform must ensure the confidentiality, integrity, and security of protected health information (PHI) in accordance with federal privacy regulations.
c. Telehealth services shall be provided in real time, not via a recording, by awake staff using the appropriate connection. While telehealth is being provided, the telehealth staff shall not have duties other than telehealth.
d. The Telehealth Provider shall provide initial and ongoing training to its staff to ensure the person knows how to use the technological equipment.
e. The Telehealth Provider shall provide an individual who receives telehealth services with initial and ongoing training on how to use the technology/equipment as specified in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

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:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Personal Emergency Response System (PERS), an electronic device that enables persons who are at high risk of institutionalization to secure help in an emergency. The person may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once the "help" button is activated. Trained professionals staff the response center. PERS services are available to those individuals who live alone, who are alone for significant parts of the day, or who would otherwise require extensive routine supervision. Coverage of the PERS is limited to the rental of the electronic device. PERS services shall include the maintenance costs and training the recipient to use the equipment, and 24-hour, 7 day a week response center service. Reimbursement will be made for an installation fee for the PERS unit. A monthly fee will be paid for the maintenance of the PERS.

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

PERS is being provided as a standalone service from Waiver Years 1-3. In Waiver Years 4 and 5, PERS is being removed as a standalone service and will be included as a service in the Assistive Technology section of this waiver.

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

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

☑ **Provider managed**

☐ **Remote/via Telehealth**

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	Licensed Therapists, Assistive Technology Professionals
Agency	Assistive Technology Professional Agency; Licensed Clinical Therapy Agency; Assistive Technology Supplier

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Licensed Therapists, Assistive Technology Professionals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

RESNA certified Assistive Technology professionals.

Other Standard *(specify):*

Approved waiver provider of OT, PT, SHL services.
Any approved HCBS IDD PERS vendor as of 11/2017 is automatically qualified as an assistive technology vendor under the IFS waiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and then annually thereafter.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Assistive Technology Professional Agency; Licensed Clinical Therapy Agency; Assistive Technology Supplier

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

RSA approved vendor; Approved waiver provider agency for OT, PT, SHL services.
Any approved HCBS IDD PERS vendor as of 11/2017 is automatically qualified as an assistive technology provider under the IFS waiver.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter.

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:

Physical Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11090 physical therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Physical Therapy (PT) services are designed to maximize independence, prevent further disability, maintain health. They are also designed to treat the identified physical dysfunction or the degree to which pain associated with movement can be reduced. They should be provided in accordance with the person's Plan of Care. All PT services will be monitored to determine which services are most appropriate to enhance the person's well-being and meet the therapeutic goals.
This is not an extended state plan service. This service may be used in addition to or in place of the state plan service if indicated as needed by the physician. This service differs from the state plan service by provider qualifications and locations where the service may be delivered. The Physical Therapy professional under the HCBS waiver is not restricted to those employed by home health agencies, hospital or clinics. This service is delivered by a licensed practitioner and may be delivered in the home, day service, or community, based upon where the services are needed.

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

If the person is between the ages of 18 and 22, the DDS Service Coordinator will ensure State Plan and Health Care Services for Children with Special Needs (HSCSN) services are exhausted prior to enrolling persons in the waiver except in circumstances where the IDT or Primary Care Physician determines that State Plan/HSCSN services and the settings where they are provided may not meet the persons individualized needs. The DDS service coordinator will ensure that EPSDT services are fully utilized and the HCBS waiver service is not replacing or duplicating service. The DDS waiver unit also serves as quality control when authorizing service plans to monitor the appropriate use of EPSDT and other State Plan services as appropriate. Services are limited to 4 hours per day and 100 hours per calendar year. Requests for additional hours may be approved when accompanied by a physician's order or if the request passes a clinical review by DDS.

This waiver service is only provided to adults age 21 and over. All medically necessary physical therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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
Individual	Physical Therapist or Physical Therapy Assistant working under the direct supervision of a licensed Physical Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS; Department of Health: Health Regulation Administration

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy

Provider Category:

Individual

Provider Type:

Physical Therapist or Physical Therapy Assistant working under the direct supervision of a licensed Physical Therapist

Provider Qualifications

License *(specify):*

A physical therapist licensed to practice physical therapy in accordance with the requirements of Chapter 67 of Title 17 of the D.C.M.R
A physical therapy assistant licensed to practice as a physical therapy assistant in accordance with the requirements of Chapter 82 of Title 17 of the D.C.M.R.

Certificate *(specify):*

Other Standard *(specify):*

A Physical Therapy Assistant shall only perform the functions in accordance with D.C. Mun. Regs. Title 17, § 8209

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

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:

Small Group Supported Employment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03022 ongoing supported employment, group
Category 2:	**Sub-Category 2:**
03 Supported Employment	03030 career planning
Category 3:	**Sub-Category 3:**
03 Supported Employment	03010 job development
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Note to CMS: We recognize that this is a statutory service; however, this web portal will not allow us to have two statutory services called "Supported Employment". Because of this, we have listed this as an "Other Service"

Small Group are services and training activities provided in regular business, industry and community settings for groups of two (2) to four (4) workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in the community. Small Group Supported Employment must be provided in a manner that promotes integration into the workplace and interaction between the workers with disabilities and those without disabilities in those workplaces.
Personal care/assistance may be a component part of supported employment, small group employment support services, but may not comprise the entirety of the service. Small Group Supported Employment includes benefits counseling, defined as analysis and advice to help the person understand the potential impact of employment on his or her public benefits, including, but not limited to: Supplemental Security Income, Medicaid, Social Security Disability Insurance, Medicare, and Food Stamps. People should be provided information to make an informed decision in choosing between supported employment, small group employment supports and supported employment individual employment support services.

Small Group Supported Employment Services provided via remote support:

This service may be rendered using remote support. The purpose of the remote support delivery option is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and promote their ability to live independently, and meaningfully participate in their community. The participant's services may not be delivered virtually one hundred (100) percent of the time. The participant must always have the option to utilize in-person services. A participant who requires in-person assistance during the provision of the service must receive services in person. The use of the remote delivery service option is not for the convenience of providers.

Requirements and methodology regarding HIPAA have been approved by the DC HIPAA Compliance Officer. Participant privacy rights will be assured and monitored on an ongoing basis. Privacy obligations will be reviewed on an ongoing basis with providers and the person receiving services. Training will be provided for participants on how to identify or report issues if they believe their privacy has been violated. Providers will not use video or telehealth support devices in participant bedrooms or bathrooms. The use of the virtual support option must not block, prohibit or discourage the use of in-person services or access to the community. Community integration will be increased by having the option for telehealth service delivery. In instances where participants may not be inclined to attend or receive a service in-person, the telehealth service delivery option affords the opportunity for the participant to still participate in services, engage with their providers, community and friends, when they otherwise would not be able to do so due to illness, transportation issues, pandemics, or

other personal reasons.

Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the telehealth delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The Individual Support Plan (ISP) must include a justification statement explaining how telehealth support assures health and safety of the individual. If it is determined that in-person assistance is required, virtual support may not be provided.

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

Supported employment group services:
1. ARE NOT provided in specialized facilities that are not a part of the general workplace;
2. DOES NOT INCLUDE volunteer work; (volunteer learning and training activities that prepare a person for entry into the paid workforce are addressed through employment readiness services); and
3. DOES NOT include payment for supervision, training, or support and adaptations typically available to other workers without disabilities filling similar positions in the business.
Time spent in transportation to and from the program shall not be included in the total amount of services provided per day. However, time spent in public transportation to and from the program for the purpose of training the person on the use of transportation services may be included in the number of hours of services provided per day for a period of time specified in the person's ISP/Plan of Care.

Day Habilitation, Employment Readiness; In-Home Supports and Individualized Day Supports shall not be used at the same time as this service.

When Supported Employment services are provided at a work site in which persons without disabilities are employees, payment will be made only for the adaptations, supervision and training required persons receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Services are not available to persons who are eligible to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401 (16) and (71).

Service Limits
1. Intake and Assessment activities shall not exceed 80 hours per calendar year.
2. Job Preparation, Development and Placement activities shall not exceed 240 hours per job placement per calendar year.
3. On the Job training shall not exceed more than 360 hours per placement per year. Additional hours may be provided as prior authorized by DDS.

Time spent in transportation to and from the service shall not be included in the total amount of services provided per day. Time spent in transportation during activities is reimbursed under Small Group Supported Employment.

The IDT will need to assess the person's ability to benefit from remote services engagement to determine how many hours the person can engage in remote supports for supported employment. Supported Employment services can be implemented partially in-person and partially remote supports.

Services cannot be delivered remotely one hundred (100) percent of the time.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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	Supported Employment Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Small Group Supported Employment

Provider Category:

Agency

Provider Type:

Supported Employment Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DDS Provider Certification Review per DDS Policy

Certified Enabling Technology Integration Specialist (ETIS) employed by a DDS Service Provider. Shift is the developmental and disability services industry's first online learning curriculum and community that standardizes best practices in Technology First programming. The program is accredited by the National Association of Direct Support Professionals. Currently, it includes two (2) programs:
1. Enabling Technology Integration Specialist Certification that provides specialized training in person-centered technology assessment and implementation; and
2. Technology First Accreditation for organizations demonstrating sustainable and standardized best practices in enabling technology integration.

Other Standard *(specify):*

Provider enrolled to provide services through DDS/DHCF and has a current Medicaid agreement. A provider must become an RSA Supported Employment provider within one year of the approval date of the waiver amendments. Owner-operators shall complete training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics determined by DDS, and in accordance with DDS published guidance within one year from the date, the waiver application becomes effective for current providers and prior to any new waiver provider becoming approved to initiate services.

For individual employees, the following requirements apply:
- Documentation that each employee is eighteen (18) years of age or older;
- Documentation that each employee was found acceptable by the individual
- Annual documentation from a physician or other official that the employees are free from communicable diseases as confirmed by an annual purified protein as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test;

- Record of completion of competency-based training in communication with people with intellectual disabilities
- Record of completion of competency-based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030;
- A high school diploma or general equivalency development;
- Certification (annual) in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDC-approved pre-services and in-service training in DDS policies and procedures;
- Training is needed to address the unique support needs of the individual as detailed in their Plan of Care; and Verification of Provider Qualifications.

Within one year of becoming a small group supported employment provider:

- The provider shall maintain evidence of completion of a professional development course that will satisfy a Basic Employment Certificate or comparable as required by the Association of Community Rehabilitation Educators (ACRE).

- In addition to the requirements stated above, for all staff working directly with persons with disabilities, particularly in job development and placement, the following topic areas should be covered by the course or training and obtained within a year:

o Application of Core Values and Principles to Practice or Federal Policy and Historical Perspective required four (4) hours

o Individualized Assessment and Employment/ Career Planning or Customer Profile and Employment Selection required six (6) hours

o Community Research and Job Development or Organizational Marketing and Job Development required five (5) hours

o Workplace and Related Supports or Job-Site Training required ten (10) hours

o Others (Specific Disabilities, Long Term Support, Funding, Benefits Counseling, etc.) required ten (10) hours

o The total hours of these services are forty (40) hours.

- This training requirement may be waived if the staff possesses a National Certificate in Employment Services or is a Certified Employment Support Professional.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially, and annually thereafter

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:

Speech, Hearing and Language Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Speech, Hearing and Language Services are designed to maximize independence, prevent further disability, and maintain health. These services will be provided in accordance with the person's Plan of Care. All Speech, Hearing and Language Therapy services will be monitored to determine which services are most appropriate to enhance the person's well-being and to meet their therapeutic goals. This is not an extended state plan service as the provider of service is not required to be associated with a home health agency, hospital or clinic. The service may be delivered in the home, day service, or community, based upon where the services are needed.

Speech, Hearing and Language Services are available both as a one-to-one service for a person and in small-group settings not to exceed 1:3. A waiver participant may utilize both one-to-one and small-group Speech, Hearing and Language Services.

Speech, Hearing, and Language Services provided via telehealth support:

This service may be rendered using telehealth support. The purpose of the telehealth support delivery option is to address a person's assessed professional, clinical, wellness, and therapeutic needs and promote autonomy, maintain or improve health outcomes, and promote real-time assessment while the person is in the community. The participant's services may not be delivered virtually one hundred (100) percent of the time. The participant must always have the option to utilize in-person services. A participant who requires in-person assistance during the provision of the service must receive services in person. The use of the telehealth delivery service option is not for the convenience of providers.

Requirements and methodology regarding HIPAA have been approved by the DC HIPAA Compliance Officer. Participant privacy rights will be assured and monitored on an ongoing basis. Privacy obligations will be reviewed on an ongoing basis with providers and the person receiving services. Training will be provided for participants on how to identify or report issues if they believe their privacy has been violated. Providers will not use video or telehealth support devices in participant bedrooms or bathrooms. The use of the virtual support option must not block, prohibit or discourage the use of in-person services or access to the community. Community integration will be increased by having the option for telehealth service delivery. In instances where participants may not be inclined to attend or receive a service in-person, the telehealth service delivery option affords the opportunity for the participant to still participate in services, engage with their providers, community and friends, when they otherwise would not be able to do so due to illness, transportation issues, pandemics, or other personal reasons.

Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the telehealth delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The Individual Support Plan (ISP) must include a justification statement explaining how telehealth support assures the health and safety the individual. If it is determined that in-person assistance is required, virtual support may not be provided.

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

This waiver service is only provided to adults age 21 and over. All medically necessary speech, hearing and language therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

The IDT will need to assess the person's ability to benefit from telehealth services engagement to determine how many hours the person can engage in telehealth support for speech, hearing, and language services. Speech, Hearing, and Language services can be implemented partially in-person and partially telehealth supports.

Services cannot be delivered via telehealth one hundred (100) percent of the time.

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

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

☑ **Provider managed**

☑ **Remote/via Telehealth**

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	Audiologists
Individual	Speech Pathologists

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech, Hearing and Language Services

Provider Category:

Individual

Provider Type:

Audiologists

Provider Qualifications

License *(specify):*

An audiologist licensed to practice audiology in accordance with the requirements of Chapter 78 of Title 17 of the D.C.M.R.

Certificate *(specify):*

Certificate of Clinical Competence in the area of Audiology granted by the American Speech Hearing Language Association

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially, and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech, Hearing and Language Services

Provider Category:

Individual

Provider Type:

Speech Pathologists

Provider Qualifications

License *(specify):*

A Speech Pathologist licensed to practice speech pathology in accordance with the requirements of Chapter 79 of Title 17 of the D.C.M.R.

Certificate *(specify):*

Other Standard *(specify):*

Accreditation by the American Speech-Language-Hearing Association.

Local IDD Waiver providers who have been certified to provide Remote Support Services can provide telehealth services. Providers furnishing Telehealth Services must meet the following requirements:
a. An individual or professional providing telehealth services shall meet all HCBS IFS waiver and state licensure or certification requirements to deliver waiver telehealth-based services, including but not limited to licensed behavioral health professionals, speech-language pathologists, occupational therapists, nutritionists, fitness trainers, registered nurses, social workers, and credentialed assistive technology specialists.
b. All Telehealth services must be delivered through a secure, HIPAA-compliant platform that supports real-time, two-way interactive audio and visual communication. The platform must ensure the confidentiality, integrity, and security of protected health information (PHI) in accordance with federal privacy regulations.
c. Telehealth services shall be provided in real time, not via a recording, by awake staff using the appropriate connection. While telehealth is being provided, the telehealth staff shall not have duties other than telehealth.
d. The Telehealth Provider shall provide initial and ongoing training to its staff to ensure the person knows how to use the monitoring technological equipment.
e. The Telehealth Provider shall provide an individual who receives telehealth services with initial and ongoing training on how to use the technology/equipment as specified in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially, and annually thereafter.

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:

Supported Living with Transportation

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02013 group living, other

Category 2:

02 Round-the-Clock Services

Sub-Category 2:

02023 shared living, other

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Note to CMS: Waiver portal will not allow us to select multiple Habilitation Statutory Services. In order to validate and submit this waiver, we changed the Service Type to "Other Service" instead of "Statutory Service - Habilitation".

This service is defined as that which provides support to people who have limited informal supports and have an assessed need for assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed-making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the person to reside in and be a part of his or her community, based upon what is important to and for the person, as documented in his or her Individualized Support Plan (ISP) and reflected in his or her Person-Centered Thinking tools.

There will be no additional supported living residences (SLRs) approved unless determined essential by the DDA Deputy Director.

Supported Living with Transportation is provided in a home that is owned or leased and operated by the agency, or owned or leased by the individual or his/her family. Transportation is included in this service to provide routine and urgent medical care transportation and facilitate community access for people. Persons served through the waiver will continue to use State Plan emergency medical transportation services to access medically necessary emergency services.

Supported Living with Transportation may be provided in a home with either one (individualized supports, two (2) or three (3) residents. All Supported Living with Transportation must fully comply with the requirements of the HCBS Settings Rule.

Payment for Supported Living is not made for cost of room and board, the cost of home maintenance, upkeep and improvement, modifications or adaptations to a home, or to meet the requirements of the applicable life safety code. Payment for Supported Living does not include payments made, directly or indirectly, to members of the individual's immediate family. Services are not reimbursed when the person is receiving Respite.

A 24-hour setting for a single person is only possible when the person is a danger to others, as determined by psychological assessment and/or court order. The psychological assessment must be updated on an annual basis to determine the continued necessity for this single 24-hour placement.

The reimbursement rate for Supported Living with Transportation includes:
a. All direct support staff and supervision of support staff;
b. All nursing oversight provided in the residence for medication administration, physician ordered protocols and procedures, charting, other supports as per physicians the physician's orders, and maintenance of Health Management Care Plan;
c. Transportation to routine and urgent medical care and to facilitate community access as approved in the ISP;
d. Programmatic supplies and fees; and,
e. Quality Assurance costs for Incident Management Systems and Staff Development and,
f. General and Administrative fees for waiver services.

Acuity evaluation to set Support Levels will be recommended by the ISP team and approved by the DDS/DDA waiver unit through review of current staffing levels, available health and behavioral records, and any available standardized acuity instrument results to determine if a person has a health or behavioral acuity that requires increased supports. Persons served through the waiver may be assessed at a Support Level that is consistent with their current staffing level if other Acuity indicators are not in place.

Payments are not made for room and board, the cost of facility maintenance, upkeep, or improvement. The cost of transportation is included in the rate.
Skilled nursing oversight in Supported Living is accounted for in the rate for routine physical assessments, as needed, the development of Health Care Management plans, Nursing assessments, as needed, oversight of non-licensed Medication Administration personnel or LPN's, and/or actual administration of medications. Skilled Nursing may also be authorized as a separate Extended State Plan Service for people who live in Supported Living except supported living with nursing.

As part of the person-centered planning process, the support team must discuss and create an individualized plan in the event that technology failures occur.

Supported Living services for people who receive drop in/ periodic supports may be provided in person, or through phone or other technological means (e.g., Skype, Facetime), where approved by the person and his or her support team and documented in the ISP.

Supported Living staffing only services are for persons residing in the natural home setting who require supports beyond the scope of in-home supports and without staffing supports and nursing oversight and coordination, the person would be unable to maintain their independence and health and wellness in the natural home. Persons receiving supported living staffing only supports must own or lease their home.

Supported living with transportation provided via remote support:

This service may be rendered using remote support. The purpose of the remote support delivery option is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and promote their ability to live independently, and meaningfully participate in their community. The participant's services may not be delivered virtually one hundred (100) percent of the time. The participant must always have the option to utilize in-person services. A participant who requires in-person assistance during the provision of the service must receive services in person. The use of the remote delivery service option is not for the convenience of providers.

Requirements and methodology regarding HIPAA have been approved by the DC HIPAA Compliance Officer. Participant privacy rights will be assured and monitored on an ongoing basis. Privacy obligations will be reviewed on an ongoing basis with providers and the person receiving services. Training will be provided for participants on how to identify or report issues if they believe their privacy has been violated. Providers will not use video or remote support devices in participant bedrooms or bathrooms. The use of the virtual support option must not block, prohibit or discourage the use of in-person services or access to the community. Community integration will be increased by having the option for remote service delivery. In instances where participants may not be inclined to attend or receive a service in-person, the remote service delivery option affords the opportunity for the participant to still participate in services, engage with their providers, community and friends, when they otherwise would not be able to do so due to illness, transportation issues, pandemics, or other personal reasons.

Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the remote delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The Individual Service Plan (ISP) must include a justification statement explaining how remote support assures health and safety If it is determined that in-person assistance is required, virtual support may not be provided.

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

This service is limited to persons who have limited informal supports and have an assessed need for assistance with acquisition, retention, or improvement in skills related to activities of daily living and the social and adaptive skills necessary to enable them to reside in and be a part of their community.

There will be no additional supported living residences (SLRs) approved unless determined essential by the DDA Deputy Director.

This service may not be used at the same time as In-Home Supports, Host Home, or Residential Habilitation. However, a person in Supporting Living with Transportation may receive Personal Care Services if they are employed and/or in school.

A 24-hour setting for a single person is available only in the following circumstances:
(a) When the person is a danger to others, as determined by the psychological assessment/and or court order. The psychological assessment must be updated on an annual basis to determine the continued necessity for this single 24-hour placement; or
(b) The person and/ or his support team have recommended that the person live in a single-person setting, and the person is able to pay for the non-waiver costs of the placement (for example, rent, utilities, etc.); or
(c) Based upon other medical or behavioral needs, when recommended by the person and/ or his support team and approved by the Deputy Director for DDA.

The IDT will need to assess the person's ability to benefit from remote services engagement to determine how many hours the person can engage in remote supports for supported living with transportation. Supported Living with Transportation services can be implemented partially in-person and partially remote supports.

Supported living with transportation (periodic) services cannot be delivered remotely one hundred (100) percent of the time.

Supported living with transportation (daily) requires in-person visits and may be delivered remotely up to seventy percent (75%) of the time the person receives supported living services per day.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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	Supported Living

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living with Transportation

Provider Category:
Agency

Provider Type:
Supported Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified Enabling Technology Integration Specialist (ETIS) employed by a Shift DDS Service Provider or Enabling Technology Credential (ETC)

Certified Enabling Technology Integration Specialist (ETIS) employed by a DDS Service Provider. Shift is the developmental and disability services industry's first online learning curriculum and community that standardizes best practices in Technology First programming. The program is accredited by the National Association of Direct Support Professionals. Currently, it includes two (2) programs:
1. Enabling Technology Integration Specialist Certification that provides specialized training in person-centered technology assessment and implementation; and
2. Technology First Accreditation for organizations demonstrating sustainable and standardized best practices in enabling technology integration."

Other Standard *(specify):*

Provider enrolled to provide services through DDS, meets DDS Basic Assurances, and has a current Medicaid agreement. Owner-operators shall complete training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics determined by DDS, and in accordance with DDS published guidance within one year from the date, the waiver application becomes effective for current providers and prior to any new waiver provider becoming approved to initiate services.
For individual employees, the following requirements apply:
- Documentation that each employee is eighteen (18) years of age or older;
- Documentation that each employee was found acceptable by the individual;
- Annual documentation from a physician or other official that the employee is free from communicable disease as confirmed by an annual
purified protein derivative of tuberculin (PPD) Skin Test; Record of completion of competency-based training in communication
with people with intellectual disabilities;
- Record of completion of competency-based training in infection control procedures consistent with the requirements of the Occupational
Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030;
- A high school diploma or general equivalency development;
- Record of completion of competency-based training in emergency procedures;
- Certification (annual) in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures; Training needed to address
the unique support needs of the individual as detailed in their Plan of Care; and
- Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal
Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), 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, $5 44-55 1 et seq.).

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially, and annually thereafter

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:

Supported Living

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02023 shared living, other
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Note to CMS: Waiver portal will not allow us to select multiple Habilitation Statutory Services. In order to validate and submit this waiver amendment, we changed the Service Type selection to "Other Service" instead of "Statutory Service - Habilitation".

This service is defined as that which provides support to persons served through the waiver who have limited informal supports and have an assessed need for assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the person to reside in and be a part of his or her community, based upon what is important to and for the person, as documented in his or her Individualized Support Plan (ISP) and reflected in his or her Person-Centered Thinking tools. The home is owned or leased either by the agency or the individual. Supported Living may be provided in a home with either one (1), two (2), or three (3) residents.

"Supported Living staffing only" services are for persons residing in the natural home setting who require supports beyond the scope of in-home supports. Additionally, without staffing supports and nursing oversight and coordination, the person would be unable to maintain their independence and health and wellness in the natural home. Persons receiving supported living staffing only must own or lease their own home.

All Supported Living settings must fully comply with the requirements of the HCBS Settings Rule.

There will be no additional supported living residences (SLRs) approved unless determined essential by the DDA Deputy Director.

Payment for Supported Living is not made for cost of room and board, the cost of home maintenance, upkeep and improvement, modifications or adaptations to a home, or to meet the requirements of the applicable life safety code. Payment for Supported Living does not include payments made, directly or indirectly, to members of the person's immediate family.

A 24-hour setting for a single person is only possible when the person is a danger to others, as determined by psychological assessment and/or court order. The psychological assessment must be updated on an annual basis to determine the continued necessity for this single 24-hour placement.

Supported Living services for people who receive drop-in/ periodic supports may be provided in person or through phone or other technological means (e.g., Skype, Facetime), when approved by the person and his or her support team and documented in the ISP.

Supported Living Rates include:
(a) All direct support staff and supervision of support staff;
(b) All nursing oversight provided in the residence for medication administration, physician-ordered protocols and procedures, charting, other supports as per the physician's orders, and maintenance of Health Management Care Plan;
(c) Programmatic supplies and fees;
(d) Quality Assurance costs for Incident Management Systems and Staff Development; and,
(e) General and Administrative fees for waiver services.

Acuity evaluation to set Support Levels will be recommended by the ISP team and approved by the DDS/DDA waiver unit through a review of current staffing levels, available health and behavioral records, and any available standardized acuity instrument results to determine if a person has a health or behavioral acuity that requires increased supports. Persons may be assessed at a Support Level that is consistent with their current staffing level if other Acuity indicators are not in place.

Payments are not made for room and board, the cost of facility maintenance, upkeep, or improvement.

Skilled nursing in Supported Living is accounted for in the rate for routine physical assessments, as needed, the development of Health Care Management plans, Nursing assessments, as needed, oversight of non-licensed Medication Administration personnel or LPN's, and/or actual administration of medications. Skilled Nursing may also be authorized as a separate Extended State Plan Service for people who live in Supported Living except for supported living with nursing.

To be eligible for Medicaid reimbursement, twenty-four (24) hour one-to-one supported living services in a single occupancy supported living residence:
(a) The person must have a history of challenging behaviors that may put others at risk, require intensive supports as determined by a psychological assessment which is updated annually or pursuant to a court order, and have a behavior support plan (BSP) that identifies the challenging behaviors and the need for one-to-one supervision that was approved by the Department on Disability Services (DDS); or
(b) The person and/or his or her support team have recommended that the person live in a single-person setting, and the person is able to pay for the non-Waiver costs of the supported living services placement (for example, rent, utilities, etc.); or
(c) The person and/or his or her support team have recommended that the person, based on medical or behavioral needs, live in a single-person setting and it has been approved by the DDS Deputy Director for DDA.

As part of the person-centered planning process, the support team must discuss and create an individualized plan in the event that technology failures occur.

Supported living provided via remote support:

This service may be rendered using remote support. The purpose of the remote support delivery option is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and promote their ability to live independently, and meaningfully participate in their community. The participant's services may not be delivered virtually one hundred (100) percent of the time. The participant must always have the option to utilize in-person services. A participant who requires in-person assistance during the provision of the service must receive services in person. The use of the remote delivery service option is not for the convenience of providers.

Requirements and methodology regarding HIPAA have been approved by the DC HIPAA Compliance Officer. Participant privacy rights will be assured and monitored on an ongoing basis. Privacy obligations will be reviewed on an ongoing basis with providers and the person receiving services. Training will be provided for participants on how to identify or report issues if they believe their privacy has been violated. Providers will not use video or remote support devices in participant bedrooms or bathrooms. The use of the virtual support option must not block, prohibit or discourage the use of in-person services or access to the community. Community integration will be increased by having the option for remote service delivery. In instances where participants may not be inclined to attend or receive a service in-person, the remote service delivery option affords the opportunity for the participant to still participate in services, engage with their providers, community and friends, when they otherwise would not be able to do so due to illness, transportation issues, pandemics, or other personal reasons.

Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the remote delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The

Individual Service Plan (ISP) must include a justification statement explaining how remote support assures health and safety If it is determined that in-person assistance is required, virtual support may not be provided.

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

This service may not be used at the same time as In-Home Supports, Host Home, or Residential Habilitation.

However, a person in Supported Living may receive Personal Care Services if they are employed and/or in school.

There will be no additional supported living residences (SLRs) approved unless determined essential by the DDA Deputy Director.

The IDT will need to assess the person's ability to benefit from remote services engagement to determine how many hours the person can engage in remote supports for supported living. Supported living services can be implemented partially in-person and partially remote supports.

Supported living (periodic) services cannot be delivered remotely one hundred (100) percent of the time.

Supported living (daily) requires in-person visits and may be delivered remotely up to seventy percent (75%) of the time the person receives supported living services per day.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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	Supported Living Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living

Provider Category:

Agency

Provider Type:

Supported Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DDS Provider Certification Review per DDS Policy

Other Standard *(specify):*

The provider should be enrolled to provide services through DDS/DHCF and have a current Medicaid agreement.
The providers may also be required to maintain a current Human Care Agreement with DDS for the provision of Residential

Services. Owner-operators shall complete training in Person-Centered Thinking, Supported Decision-Making, Supporting Community Integration, and any other topics determined by DDS, and in accordance with DDS published guidance within one year from the date, the waiver application becomes effective for current providers and prior to any new waiver provider becoming approved to initiate services.

For individual employees, the following requirements apply:
- Documentation that each employee is eighteen (18) years of age or older:
- Documentation that each employee was found acceptable by the individual;
- Annual documentation from a physician or other official that the employee is free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test;
- Record of completion of competency-based training in communication with people with intellectual disabilities;
- Record of completion of competency-based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030;
- A high school diploma or general equivalency development;
- Record of completion of competency-based training in emergency procedures;
- Certification (annual) in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures; Training needed to address the unique support needs of the individual as detailed in their Plan of Care; and
- Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), 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, $5 44-55 1 et seq.).

Sec. 12006 (a) of the 21st Century Cures Act mandates that states implement Electronic visit verification (EVV) system required for all Medicaid personal care services and home health care services that require an in-home visit by a provider. This is only applicable to Supported Living periodic, not 24-hour services.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially, and annually thereafter

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:

Wellness Services

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11040 nutrition consultation

Category 2:

11 Other Health and Therapeutic Services

Sub-Category 2:

11130 other therapies

Category 3:

11 Other Health and Therapeutic Services

Sub-Category 3:

11010 health monitoring

Category 4:

11 Other Health and Therapeutic Services

Sub-Category 4:

11020 health assessment

Service Definition *(Scope):*

"Wellness Services (previously named "Professional Services" in the prior waiver) are direct services to people served through the waiver, based on need and specified in an approved Plan of Care.

Wellness Services offered are:
• Massage Therapy
• Healthy Relationships Education provides tailored education, instruction, and support on fostering healthy relationships and addressing personal safety, hygiene, consent, and appropriate social behavior to enhance the person's well-being and enable the person to live safely in the community;
• Fitness Training (services are available both as a one-to-one service to a person and in small group settings not to exceed 1:2. A waiver participant may utilize both 1:1 and small group fitness
services);
• Nutrition evaluation/consultation and
• Bereavement counseling.

Wellness Services may be utilized to:
• Assist in increasing the person's independence, participation, emotional well-being, and productivity in their home, work and community;
• Provide training or therapy to a person and/or their natural and formal supports, necessary to either develop critical skills that may be self-managed by the person or maintained according to the person's needs;
• Perform assessments and/or re-assessments and recommendations;
• Provide consultative services and recommendations; and
• Provide necessary information to the person, family, caregivers, and/or team to assist in planning and implementing plans per the approved Plan of Care.

The specific service delivered must be consistent with the scope of the license held by the professional. Service intensity, frequency, and duration will be determined by individual need. The services may be short-term, intermittent, or long-term, depending on the need. The team developing the plan of support makes determinations for service utilization.

The person may utilize one or more Wellness Services on the same day, but not at the same time.

Wellness Services provided via telehealth support:

This service may be rendered using telehealth support. The purpose of the telehealth support delivery option is to assess professional, clinical, wellness, and therapeutic needs and promote autonomy, maintain or improve health outcomes, and promote real-time assessment while the person is in the community. The participant's services may not be delivered virtually one hundred (100) percent of the time. The participant must always have the option to utilize in-person services. A participant who requires in-person assistance during the provision of the service must receive services in person. The use of the telehealth delivery service option is not for the convenience of providers.

Requirements and methodology regarding HIPAA have been approved by the DC HIPAA Compliance Officer. Participant privacy rights will be assured and monitored on an ongoing basis. Privacy obligations will be reviewed on an ongoing basis with providers and the person receiving services. Training will be provided for participants on how to identify or report

issues if they believe their privacy has been violated. Providers will not use video or telehealth support devices in participant bedrooms or bathrooms. The use of the virtual support option must not block, prohibit or discourage the use of in-person services or access to the community. Community integration will be increased by having the option for telehealth service delivery. In instances where participants may not be inclined to attend or receive a service in-person, the telehealth service delivery option affords the opportunity for the participant to still participate in services, engage with their providers, community and friends, when they otherwise would not be able to do so due to illness, transportation issues, pandemics, or other personal reasons.

Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the telehealth delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The Individual Support Plan (ISP) must include a justification statement explaining how telehealth support assures health and safety of the individual. If it is determined that in-person assistance is required, virtual support may not be provided.

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

To promote the use of natural supports and ensure appropriate utilization/delivery of, the following limitations apply to Wellness Services:

- Massage Therapy: Limited to 52 hours per ISP year; extension of up to 100 hours per year may be authorized with approval by the DDA Deputy Director, based upon the person's assessed medical or clinical need (e.g., someone with CP who has severe contractures and would benefit from massage therapy).

- Healthy Relationships Education: Limited to 52 hours per ISP year. An extension of additional hours, up to one hundred (100) hours per year, may be authorized with approval by the DDA Deputy Director based upon the person's assessed medical or clinical need. The IDT will need to assess the person's ability to benefit from telehealth services engagement to determine how many hours the person can engage in telehealth supports for Healthy Relationships Education. Healthy Relationships Education services can be implemented partially in-person and partially telehealth supports.

- Fitness Training: Limited to 52 hours per ISP year for persons who use Host Home, Supported Living, Supported Living with Transportation, Residential Habilitation, or In-Home Supports, or who otherwise have natural supports available that can help the person practice the skills learned in fitness training and achieve their fitness goals. Limited to 104 hours per year for persons who live in natural homes, without In-Home Supports, and who do not have such natural supports available (e.g., people who live with aging parents). The IDT will need to assess the person's ability to benefit from telehealth services engagement to determine how many hours the person can engage in telehealth supports for Fitness Training. Fitness Training services can be implemented partially in-person and partially telehealth supports.

- Nutrition: Limited to 26 hours ISP per year for persons who have natural or paid supports available who can help them implement the skills learned and achieve their nutrition goals outside of time spent with the nutritionist. An extension of up to 104 hours per year may be authorized with approval by the DDA Deputy Director, based upon the person's assessed medical or clinical need. The IDT will need to assess the person's ability to benefit from telehealth services engagement to determine how many hours the person can engage in telehealth supports for nutrition services. Nutrition services can be implemented partially in-person and partially telehealth supports.

- Bereavement: Limited to 100 hours per ISP year. Additional hours may be authorized before the expiration of the ISP year and when the person's health and safety are at risk and the person is demonstrating progress towards achieving established outcome and/or maintenance of goals. Requests for additional hours may be approved when accompanied by a physician's order or if the request passes a clinical review by staff designated by DDS. The IDT will need to assess the person's ability to benefit from telehealth services engagement to determine how many hours the person can engage in telehealth supports for bereavement services. Bereavement services can be implemented partially in-person and partially telehealth supports.

Services cannot be delivered via telehealth one hundred (100) percent of the time.

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

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

☑ **Provider managed**

☑ **Remote/via Telehealth**

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	Massage Therapist
Individual	Dietetic/Nutrition Counselor
Agency	Home Care Agency
Individual	Bereavement Counseling
Agency	Healthy Relationships Education
Individual	Fitness Trainer

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Services

Provider Category:

Individual

Provider Type:

Massage Therapist

Provider Qualifications

License *(specify):*

Chapter 75 of Title 17 of the District of Columbia Municipal Regulations

Certificate *(specify):*

Other Standard *(specify):*

Massage Therapists shall be licensed pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 et seq. (2012 Repl. & 2014 Supp.)) and certified by the National Certification Board for Therapeutic Massage and Bodywork, or other equivalent national certification, as approved by DDS.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Services

Provider Category:

Individual

Provider Type:

Dietetic/Nutrition Counselor

Provider Qualifications

License *(specify):*

Dietetic and nutrition counselors shall be licensed pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 et seq. (2007 Repl. & 2012 Supp.)

Certificate *(specify):*

Other Standard *(specify):*

Local IDD Waiver providers who have been certified to provide Remote Support Services can provide telehealth services. Providers furnishing Telehealth Services must meet the following requirements:
a. An individual or professional providing telehealth services shall meet all HCBS IFS waiver and state licensure or certification requirements to deliver waiver telehealth-based services, including but not limited to licensed behavioral health professionals, speech-language pathologists, occupational therapists, nutritionists, fitness trainers, registered nurses, social workers, and credentialed assistive technology specialists.
b. All Telehealth services must be delivered through a secure, HIPAA-compliant platform that supports real-time, two-way interactive audio and visual communication. The platform must ensure the confidentiality, integrity, and security of protected health information (PHI) in accordance with federal privacy regulations.
c. Telehealth services shall be provided in real time, not via a recording, by awake staff using the appropriate connection. While telehealth is being provided, the telehealth staff shall not have duties other than telehealth.
d. The Telehealth Provider shall provide initial and ongoing training to its staff to ensure the person knows how to use the technological equipment.
e. The Telehealth Provider shall provide an individual who receives telehealth services with initial and ongoing training on how to use the technology/equipment as specified in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially, and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Services

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Local IDD Waiver providers who have been certified to provide Remote Support Services can provide telehealth services. Providers furnishing Telehealth Services must meet the following requirements:

a. An individual or professional providing telehealth services shall meet all HCBS IFS waiver and state licensure or certification requirements to deliver waiver telehealth-based services, including but not limited to licensed behavioral health professionals, speech-language pathologists, occupational therapists, nutritionists, fitness trainers, registered nurses, social workers, and credentialed assistive technology specialists.
b. All Telehealth services must be delivered through a secure, HIPAA-compliant platform that supports real-time, two-way interactive audio and visual communication. The platform must ensure the confidentiality, integrity, and security of protected health information (PHI) in accordance with federal privacy regulations.
c. Telehealth services shall be provided in real time, not via a recording, by awake staff using the appropriate connection. While telehealth is being provided, the telehealth staff shall not have duties other than telehealth.
d. The Telehealth Provider shall provide initial and ongoing training to its staff to ensure the person knows how to use the technological equipment.
e. The Telehealth Provider shall provide an individual who receives telehealth services with initial and ongoing training on how to use the technology/equipment as specified in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS; DOH, HRLA

Frequency of Verification:

Initially, and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Services

Provider Category:

Individual

Provider Type:

Bereavement Counseling

Provider Qualifications

License *(specify):*

Licensed in accordance with District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 et seq. (2007 Rep. & 2012 Supp.))

Certificate *(specify):*

Certified Grief Counselor/American Academy of Grief Counseling

Other Standard *(specify):*

Bereavement counseling services shall be performed by a person who has been certified by the American Academy of Grief Counseling or other equivalent national certification, as approved by DDS.

Local IDD Waiver providers who have been certified to provide Remote Support Services can provide telehealth services. Providers furnishing Telehealth Services must meet the following requirements:
a. An individual or professional providing telehealth services shall meet all HCBS IFS waiver and state licensure or certification requirements to deliver waiver telehealth-based services, including but not limited to licensed behavioral health professionals, speech-language pathologists, occupational therapists, nutritionists, fitness trainers, registered nurses, social workers, and credentialed assistive technology specialists.
b. All Telehealth services must be delivered through a secure, HIPAA-compliant platform that supports real-time, two-way interactive audio and visual communication. The platform must ensure the confidentiality, integrity, and security of protected health information (PHI) in accordance with federal privacy regulations.
c. Telehealth services shall be provided in real time, not via a recording, by awake staff using the appropriate connection. While telehealth is being provided, the telehealth staff shall not have duties other than telehealth.
d. The Telehealth Provider shall provide initial and ongoing training to its staff to ensure the person knows how to use the technological equipment.
e. The Telehealth Provider shall provide an individual who receives telehealth services with initial and ongoing training on

how to use the technology/equipment as specified in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially,and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Services

Provider Category:

Agency

Provider Type:

Healthy Relationships Education

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

(a) Any of the following professionals with specialized training in Healthy Relationships Education:

(1) Psychologist;

(2) Psychiatrist;

(3) Licensed Clinical Social Worker;

(4) Licensed Professional Counselor; or

(5) Other equivalent national certification as approved by DDS.

Other Standard *(specify):*

Local IDD Waiver providers who have been certified to provide Remote Support Services can provide telehealth services. Providers furnishing Telehealth Services must meet the following requirements:
a. An individual or professional providing telehealth services shall meet all HCBS IFS waiver and state licensure or certification requirements to deliver waiver telehealth-based services, including but not limited to licensed behavioral health professionals, speech-language pathologists, occupational therapists, nutritionists, fitness trainers, registered nurses, social workers, and credentialed assistive technology specialists.
b. All Telehealth services must be delivered through a secure, HIPAA-compliant platform that supports real-time, two-way interactive audio and visual communication. The platform must ensure the confidentiality, integrity, and security of protected health information (PHI) in accordance with federal privacy regulations.
c. Telehealth services shall be provided in real time, not via a recording, by awake staff using the appropriate connection. While telehealth is being provided, the telehealth staff shall not have duties other than telehealth.
d. The Telehealth Provider shall provide initial and ongoing training to its staff to ensure the person knows how to use the technological equipment.
e. The Telehealth Provider shall provide an individual who receives telehealth services with initial and ongoing training on how to use the technology/equipment as specified in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initially and annually thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Services

Provider Category:

Individual

Provider Type:

Fitness Trainer

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Any of the following national and/ or international certifications, or other equivalents as approved by DDS:
American Fitness Professionals and Associates
National Athletic Training Association
National Academy of Sports Medicine
Aerobics and Fitness Association of America
American College of Sports Medicine

Other Standard *(specify):*

Bachelor's level degree in physical education, health education, exercise science, or kinesiology (including Recreational therapist).

Local IDD Waiver providers who have been certified to provide Remote Support Services can provide telehealth services. Providers furnishing Telehealth Services must meet the following requirements:
a. An individual or professional providing telehealth services shall meet all HCBS IFS waiver and state licensure or certification requirements to deliver waiver telehealth-based services, including but not limited to licensed behavioral health professionals, speech-language pathologists, occupational therapists, nutritionists, fitness trainers, registered nurses, social workers, and credentialed assistive technology specialists.
b. All Telehealth services must be delivered through a secure, HIPAA-compliant platform that supports real-time, two-way interactive audio and visual communication. The platform must ensure the confidentiality, integrity, and security of protected health information (PHI) in accordance with federal privacy regulations.
c. Telehealth services shall be provided in real time, not via a recording, by awake staff using the appropriate connection. While telehealth is being provided, the telehealth staff shall not have duties other than telehealth.
d. The Telehealth Provider shall provide initial and ongoing training to its staff to ensure the person knows how to use the technological equipment.
e. The Telehealth Provider shall provide an individual who receives telehealth services with initial and ongoing training on how to use the technology/equipment as specified in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

DDS

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 section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 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.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

The Service Coordinator from DHCF's delegated operating agency, Department on Disability Services (DDS) coordinates case management for individuals receiving HCBS IDD waiver services.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Day Habilitation
Employment Readiness
In-Home Supports
Supported Employment
Assistive Technology Services
Behavioral Supports
Creative Arts Therapies
Family Training
Health Assessment and Coordination
Occupational Therapy
Parenting Supports
Small Group Supported Employment
Speech, Hearing and Language Services
Supported Living with Transportation
Supported Living
Wellness Services

1. Will any in-person visits be required?

- ◉ **Yes.**

○ **No.**

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

☑ **The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc.** ***Explain:***

The District will ensure that providers follow all local and federal privacy laws when assist an individual with this service. Telehealth sessions must place in a private setting that ensures dignity, confidentiality, and compliance with HIPAA requirements. Sessions may not occur in locations or circumstances where an individual's privacy could be compromised. Video or remote support devices shall not be used or placed in participants bedrooms and bathrooms, per DDS respective regulations and policy.

☑ **How the telehealth service delivery will facilitate community integration.** ***Explain:***

Telehealth will facilitate community integration by ensuring that DDS individuals have the same access to services as others in their communities.

☑ **How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual.** ***Explain:***

Telehealth allows individuals to consult with healthcare professionals remotely, enabling them to receive guidance, discuss specific needs, and get personalized recommendations without the need for physical presence. Additionally, telehealth can assist with geographical barriers, allowing individuals to access specialists and expertise that may not be readily available close to home. Telehealth appointments eliminate the need for travel to a clinic, saving time and effort for individuals with disabilities. For telehealth services such as occupational therapy, and fitness training, which may require hands-on assistance when delivered in person, the support planning team and the service provider must determine whether the service can be effectively delivered remotely to the person supported. Telehealth services that do not require hands-on assistance, such as behavioral supports, speech and language therapy, nutrition, and counseling services can be delivered virtually without a need for hands-on assistance. However, a person who requires in person assistance during the provision of a service shall receive services in person and not through remote supports, per DDS respective waiver regulations and policy.

☑ **How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service.** ***Explain:***

There are safeguards in place as outlined in the remote services section of the waiver. Participants who need assistance with acquiring technology can access Assistive Technology waiver services. Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the remote delivery of waiver services.

☑ **How the telehealth will ensure the health and safety of an individual.** ***Explain:***

Telehealth allows patients to receive care in a familiar and comfortable setting, potentially reducing anxiety and stress associated with traditional environments. Additionally, all telehealth services will be delivered in compliance with all District and federal privacy laws. Telehealth professionals ensure the safe and appropriate delivery of waiver services in compliance with HIPAA and clinical standards, but are not expected to assume responsibility for the total health and safety in the person's environment.

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 DDS FTE service coordinators receive criminal background checks and direct care providers must undergo criminal background checks.
(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.

Annually, a representative sample of personnel records are reviewed to ensure compliance. As a condition of participation in the Medicaid program, each Home HealthCare Agency shall ensure that each direct care provider has passed a criminal background check. Criminal background check reviews are completed via sampling of provider records during the Provider Certification Review (PCR) process.

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, § 44-551et seq.) The (District) Metropolitan Police Department is the entity responsible for conducting all criminal background checks for staff of all agencies.

The Department on Disability Services is responsible for reviewing a sample of all personnel records to ensure that the check is indeed conducted during PCR.

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; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. 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 is contained in response to C-5.

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 or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring 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.*

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 types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures 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.*

○ **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:

The following processes are used to assure that all willing and qualified providers have the opportunity to enroll as Waiver providers. All qualified waiver providers are accepted as providers of care. All criteria for Waiver providers are printed and available to any and all interested providers. This information will be available on-line and at the DHCF and DDS Offices. Licensure Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached to the application packet.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

○ **No, the state does not choose the option to provide HCBS in acute care hospitals.**

● **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*

☑ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**

☑ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**

☑ **The HCBS must be identified in the individual's person-centered service plan; and**

☑ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

*And specify:***(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

All eligible in-home support and supported living services may be provided in an acute care hospital for the purposes of supporting an individual's personal, behavioral, and communication needs not otherwise provided in that setting. While a waiver participant is temporarily hospitalized in an acute care hospital setting, waiver services will be provided in accordance with the service specifications that are individually listed in Appendix C-1-a and defined in the waiver service specifications in Appendix C-3.

These services may be provided in an acute care hospital under the following conditions:

(A) Identified in a person's individual support plan;
(B) Provided to meet needs of the individual that are not met through the provision of acute care hospital services;
(C) Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement;
(D) The District has mechanisms in place to prevent duplicate billing for both institutional and home and community-based services; and
(E) Designed to ensure smooth transitions between acute care hospitals and home and community-based settings, and to preserve the individual's functional abilities.

For IDD waiver participant that are in acute care hospitals, the utilization of HCBS may assist with returning to the community my maintaining and/or developing an individualized person-centered plan, the development of a community-based network of support, the strengthening of and/or maintenance of levels of independence that were in place prior to hospitalization and the preparation for the person to return to the community. There will be a difference in the rate for HCBS that are provided during a hospitalization from that of the typical billing rate of supported living and in-home supports, as the rate for DSP supports provided during hospitalization will be equivalent to the rate for supported living periodic, up to 16 hours per day. The rate remains the same whether the service is provided in an HCBS or an acute care hospital setting.

Medicaid reimbursable state option to provide HCBS in acute care hospital services, which are delivered in a hospital setting, shall include the following:

(a) Identified by the acute care medical team or DDS nurse consultant as an unmet need;
(b) Recommended to DDS by the person supported or the person's support team for each incident of acute hospitalization;
(c) Identified as a need in the person's Supplemental Staffing Plan, ISP and Plan of Care (POC) and
(d) Prior authorization by the Department on Disability Services (DDS) before the commencement of services and supports.

The necessary waiver services needed in an acute care hospital setting:

(a) Must be identified in the person's ISP;
(b) Documented in the Supplemental Staffing Plan, submitted by the provider for support team and DDS approval.

The supplemental staffing plan shall include:
a. Specific non-medical services to be provided by the DSP;
b. Anticipated duration of the service shall not exceed estimated discharge date or 90 days, whichever is shorter; and
c. Supplemental staffing schedule.
(c) Must be provided to meet the person's non-medical needs that are not covered in such settings;
(d) Should not substitute for services that the setting is obligated to provide through its condition of participation under federal or D.C. law, or under another applicable requirement;
(e) Should be utilized to ensure smooth transitions between the setting and the home and community-based setting and preserve the person's functional abilities; and
(f) Shall not exceed ninety (90) consecutive calendar days per ISP year unless an extension has been granted by the DDS Deputy Director or designee. Approval of a request for additional days of supplemental staffing, exceeding 90 days must be submitted by the provider to the DDS Deputy Director or designee.1945.9 The staffing to person ratio for DSPs supports in acute care hospital settings is one-to-one (1:1).

In order to be eligible for Medicaid reimbursement, each provider of Medicaid reimbursable state option to provide HCBS in acute care hospital settings services shall maintain the following documents for monitoring and audit reviews, as applicable:

(a) The documentation and data collection related to the implementation of HCBS provided by the DSP, as required by the waiver regulations for each waiver service;
(b) The record demonstrating that the data was reviewed by the appropriate behavior support plan (BSP) staff; and
(c) The documents required to be maintained under Section 1909 (Records and Confidentiality of Information) of Chapter 19 of Title 29 DCMR.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

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:
QP.a.i.a.PM.2. Percentage of newly enrolled waiver providers meet initial quality and business standards prior to service provision. Number of provider applications that meet standards (numerator)/Number of new providers that were approved to enroll in the IDD HCBS Waiver program (denominator)

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
QAPMA/Provider Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
QP.a.i.a.PM.1. Percentage of licensed clinicians continue to meet applicable licensure requirements. Number of licensed clinicians with appropriate credentials (numerator)/Number of licensed clinicians eligible to provide services (denominator)

Data Source (Select one):
Other
If 'Other' is selected, specify:
License Database

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP.a.i.a.PM.3. Percentage of providers continue to meet applicable certification standards. Number of waiver providers that continue to meet required certification standards (numerator)/ Number of waiver providers that are subject to certification (denominator)

Data Source (Select one):
Other
If 'Other' is selected, specify:
QAPMA/Provider Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP.a.i.a.PM.4. Percentage of providers correct identified deficiencies cited during certification reviews. Number of corrected deficiencies on time (numerator)/Number of identified deficiencies due to be corrected (denominator)

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCIS/Applicable DDS electronic information system

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

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:
QP.a.i.c.PM.1. Percentage of Certified providers train staff according to DDS policies and procedures. Number of providers that meet all applicable training indicators on the PCR (numerator)/Number of providers reviewed through certification (denominator).

Data Source (Select one):
Other
If 'Other' is selected, specify:
QAPMA/Provider Database

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

QP.a.i.a.PM.1. Newly enrolled waiver providers meet initial quality and business standards prior to service provision (Number of provider applications that meet standards/Number of new providers that were approved to enroll in the IDD Waiver program)

Providers that have not previously been certified for any services by DDS will be subject to "pre-qualification" requirements conducted by the Quality Resource Unit (QRU) in order to be listed as a qualified provider. If selected to provide a service subject to licensure and/or certification, the Provider Certification Review (PCR) Team will conduct an abbreviated review according to the existing certification process after providing services for 2 months. Within 6 months of initiating services, the provider will be subject to a full certification review. When a provider application is denied, the QRU will record the reasons for denial in the database. That data will be aggregated and analyzed to determine if there are consistent reasons across applications that require corrective action on the part of the District that will improve success rate in application approvals.

QP.a.i.a.PM.4. Licensed clinicians continue to meet applicable licensure requirements (Number of licensed clinicians with appropriate credentials/Number of licensed clinicians eligible to provide services)

QRU verifies qualifications for waiver providers both for licensed professionals and non-licensed providers prior to the provision of services and at least annually thereafter. Clinicians who do not present proof of current licensure will be suspended from the waiver program.

QP.a.i.a.PM.3. New providers pass an initial certification review to provide supports. (Number of new providers that received certification to continue to operate within 6 months of initial delivery of services to waiver individuals/Number of new providers that were approved and initiated delivery of supports)

QP.a.i.c.PM.9. Certified providers train staff according to DDS training policy and procedure (Number of providers that meet applicable training indicators in the PCR/Number of providers reviewed through certification)

The PCR Team monitors providers of direct services and evaluates providers based upon a set of key domains. Providers of residential habilitation, supported living, in-home, host-home, respite, supported employment, day habilitation, individualized day, and employment readiness are subject to on site reviews annually. This review includes a random sample of individuals served by the provider and is representative of the types of services and supports provided. In addition, an organizational review is conducted to assure that the agency is positioned to support quality across all its services and supports. The organizational review includes a thorough review of the systems to protect and promote rights, mitigate risks, ensure that staff is qualified and competent, and ensure that service delivery supports independence, skills

acquisition and quality management strategies. PCR Team observe individuals on site, interview individuals, family members and key staff, and review documentation. Each provider is reviewed every year, at a minimum.

Providers that fail to meet the standards of the Provider Certification Review are referred to DHCF with a recommendation for termination from the I/DD HCBS waiver program. Providers that fail to maintain individual Residential Habilitation home licensure by the Department of Health are placed on enhanced monitoring for all Residential Habilitation services by DDS until a plan of correction is successfully met.

Aggregated findings by performance domain areas are summarized and reported monthly to the DDS Quality Management Director. The DDS Quality Assurance and Performance Management Administration (QAPMA) reports quarterly summary findings to the Quality Improvement Committee (QIC) for any remediation/improvement recommendations as appropriate.

QP.a.i.a.PM.6. Providers correct identified deficiencies cited during certification reviews (Number of corrected deficiencies on time/Number of identified deficiencies).

QAPMA in collaboration with other DDA work units, as necessary, conducts remediation activities as outlined in the waiver application to ensure providers correct any deficiencies cited during any PCR activity.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Through formal and informal monitoring activities, all DDA staff and contractors identify and report individual and provider issues by entering them into the Issue Resolution System in MCIS/Applicable DDS electronic information system. The Immediate Response Committee (IRC) assigns the issue to the appropriate staff. The assigned staff document activities and closure in MCIS/Applicable DDS electronic information system. Issues are tracked with due dates on DDA personnel performance management dashboards and are monitored by direct supervisory personnel and quarterly by the DDA Performance Management Meeting process.

Review data entered into the provider database and DDS electronic information system as needed to make recommendations to all staff as necessary.

DDA maintains information within our internal case management system of all clinicians working for certified, Medicaid Providers (enrolled by DHCF and info kept in MMIS) who provide therapies to waiver enrollees. The spreadsheet contains the clinician therapy they are licensed to provide, the date of their licenses issuance and the expiration.

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**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

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.

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 in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

Individuals receive services in home and community based-services residential settings, in their natural homes, homes within the community to include family or friends, and acute care hospital settings.

Home and community-based residential settings include host home, residential habilitation, and supported living. Host home settings are owned or leased by the principal care provider residing in the home and enables people to live in the community in a family-type setting. Residential habilitation settings, provided by an agency in a licensed home that is owned or leased by the agency, serving four to six people and offers blended services developed in accordance with the needs of the person. Supported living settings, provided by an agency in a home owned or leased by the waiver provider or by the person receiving supported living services, serving one to three people and offers blended services based on the persons needs and can be provided with or without transportation.

Additionally, day habilitation services are delivered in a group setting at a day habilitation facility, employment within the community, various community settings (e.g., shopping, entertainment, museums, libraries, etc.), or can be provided as day habilitation one-to-one services in the community. Day habilitation services may also be delivered in small group settings at a ratio of 1:3 for persons who are medically or behaviorally complex. Small group day habilitation settings must include integrated skills building in the community and support access to the greater community. Small group day habilitation: (a) Shall not be provided in the same building as a large day habilitation facility setting; (b) Shall be located in places that facilitate community integration and inclusion; (c) Shall fully comply with the requirements of the HCBS Settings Rule; and (d) Shall not be delivered in settings that have a daily census larger than fifteen (15) persons.

Employment Readiness and supported employment services are provided at a day habilitation program or within the community. All services are provided in settings that comply with waiver services and federal regulations. Services are also provided in transitional settings. Transitional settings are those where an individual resides in a transitional living home for 30 days or less.

Respite services can be offered in a person's home or another residential setting that would meet the requirements of certifications issued by the Department on Disability Services (DDS); Supported Living Provider-not to exceed 3 people; Residential Habilitation Provider-not to exceed 4 people as currently approved; or Home Health Agency.

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring*

across residential and non-residential settings in which waiver HCBS are received.)

DDS monitors all HCBS settings on a quarterly and annual basis to ensure compliance with HCBS Settings requirements by using the various assessment tools, including a Provider Certification Review, Provider Performance Review, and the Service Coordination Monitoring Tool, which incorporates the HCBS settings requirements. This monitoring process will account for compliance with the HCBS settings rule and associated policies and procedures of the provider/licensee.

The District assures that all waiver settings/providers authorized in this submission comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Services included under this waiver are provided in the person's home or place of residence and other locations in the community, including day habilitation and employment readiness fixed-site facilities. All settings have been determined to meet the settings requirements. Participants' private homes are presumed compliant. To ensure the private home continues to meet the person's needs, DDS service coordinators monitor IDD Waiver participants in their natural home setting quarterly and conduct monthly contacts. Monitoring includes a review of the environment and interview with the person. Issues that constitute a health or safety risk for the person are tracked, resolved, and documented in DDS' issue resolution system.

DDS service coordinators conduct 100% on site assessments of all IDD waiver residential settings including those that are individual, privately owned homes. Provider operated settings are assessed using the personal experience assessment tool which requires on site observations and interviews. This assessment is done as an extension of regular service coordination monitoring. All service coordinators are qualified intellectual developmental disability professionals, are trained in person centered thinking (PCT), and have experience working with people with disabilities and their families. The first review was completed in July of 2016 and has occurred annually thereafter. The second set 100% on site assessments was completed in July of 2017. DC included the results of the assessment as the attachment to the 2019 statewide plan transition plan update. In addition to the 100% site assessment completed by DDS service coordinators, DDS also assesses residential providers compliance with the HCBS settings rule through provider certification review. This includes a 100% organizational assessment of each provider as well as an observation and interviews of a sample of people served by the program. The Provider Certification Review (PCR) team visits approximately 25% of all residential settings annually. PCR identifies areas of non-compliance, and if this generates issues, the team provides technical assistance and requires providers to draft a plan of correction. PCR provides the DDS director with quarterly reports on provider compliance.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

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

☑ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***

☑ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

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

☑ **Facilitates individual choice regarding services and supports, and who provides them.**

☑ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

○ **No, the waiver does not include provider-owned or controlled settings.**

● **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures

that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

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

☑ **Each individual has privacy in their sleeping or living unit:**

- ☑ **Units have entrance doors lockable by the individual.**
- ☑ **Only appropriate staff have keys to unit entrance doors.**
- ☑ **Individuals sharing units have a choice of roommates in that setting.**
- ☑ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☑ **Individuals have the freedom and support to control their own schedules and activities.**

☑ **Individuals have access to food at any time.**

☑ **Individuals are able to have visitors of their choosing at any time.**

☑ **The setting is physically accessible to the individual.**

☑ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Support Plan

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(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:

Service Coordinators must meet one of the following minimum qualifications:
• Bachelor's degree in a human service-related field and one (1) year of direct service experience with people with intellectual or developmental disabilities; or
• Bachelor's degree in any field and three (3) years' experience working with people with intellectual or developmental disabilities under the supervision of a Qualified Developmental Disabilities Professional (QDDP).

Ineligibility for Concurrent Employment:
Service coordinators may not be concurrently employed by a DC certified Developmental Disabilities Administration provider of HCBS Waiver service.

Training and Competency requirements:
Each service coordinator must possess the necessary skills to:
1. Create person centered plans;
2. Coordinate services and monitor the quality and provision of services;
3. Conduct the annual HCBS setting assessment (to ensure compliance with the HCBS Settings Rule); and
4. Safeguard and protect individual rights including freedom from abuse and neglect.
As evidenced by an orientation program of at least 8 hours that addresses the following:
1. Person Centered Thinking
2. HCBS Settings Rule and HCBS Assessments
3. Positive Behavior Supports
4. Restrictive Controls Review and Human Rights Committee
5. Serious Reportable Incident Training to include reporting Abuse, Neglect and Exploitation.

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

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 initial Individual Support Plan (ISP)meeting is developed within ninety (90) days of enrollment in the IDD HCBS Waiver. Prior to the completion of the initial ISP (completed by the assigned Service Coordinator in the Service Coordination and Planning Division (SPCD), the intake Service Coordinator arranges for any emergency services such as residential placement, medical, psychiatric, or behavioral intervention.

The DDS/DDA Intake and Eligibility Determination Unit, informs people about available services and supports to assist with the service plan development process. People are informed of the choice between institutional (ICF) and HCBS services to ensure that people are able to make an "informed choice". The LON assessment is completed during the intake and eligibility process and at least annually prior to the level of care determination.

The person's assigned Service Coordinator explains all applicable services in the Waiver to enable the person and his/her family or legal representatives to make informed choices. The person is also informed of all procedural safeguards, their rights and responsibilities, how to request a change of providers, and the District's grievance and complaint procedures.

The ISP is developed through a collaborative support team process involving the person, family, friends or other support systems, legal representatives, the Service Coordinator, appropriates professionals/service providers, and others who the person chooses to be involved.

Prior to the initial or annual ISP meeting, the Service Coordinator engages in pre-planning activities ensuring that all pertinent meeting documentation is gathered timely. He/she contacts the person receiving services (and their family/legal representatives, as appropriate) to determine preferences for meeting attendees, dates, times and location understanding that the person has the right to determine who is a member of the team as all team members know and work with the person with the involvement necessary to achieve the outcomes desired by the person. The service coordinator is also responsible for communicating all agreed upon meeting information to the person and all members of the support team.

The service coordinator initiates and commits the Level of Need tool prior to the agreed upon ISP meeting date in order to obtain assessment information that will be reviewed during the ISP meeting. During the ISP meeting, while using various person centered approaches and tools, the service coordinator discusses the person's current circumstances including (but not limited to): his or her home residential needs, employment goals, and current supports. The importance of social networks and unpaid relationships are emphasized and ultimately a plan to advance the person on his or her pathway to competitive integrated employment and community integration is developed. Finally, the Service Coordinator is responsible for informing the individual of his/her freedom of choice of providers during the ISP meeting and more frequently as needed, should a situation arise mid-cycle during the ISP year which requires consideration of a provider change. The Service Coordinator has the responsibility of ensuring that this information drives the development of the ISP. A standardized person-centered planning format is used throughout the ISP development process.

The person has the right to determine who is a member of the team. The ISP/Plan of Care is developed by the team, and includes the person, their family/legal representatives (as appropriate), the Service Coordinator and others invited by the person. These team members know and work with the person and their active involvement is necessary to achieve the outcomes desired by the person.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. 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):

The ISP is developed through a collaborative support team process involving the person, family, friends or other support systems, legal representatives, the Service Coordinator, appropriate professionals/service providers, and others who the person chooses to be involved. Prior to the annual ISP meeting the DDA Service Coordinator initiates the creation or updating of a Level of Need(LON) tool, a notification is sent to team members when the tool is in the agency data base/information system so that other team members may add necessary information and so that the Service Coordinator can then complete the tool.

A person who is newly eligible to DDA services has an initial LON completed by the Intake and Eligibility Determination Unit. Upon transfer to the continuing services unit and election by the person to participate in the HCBS Waiver program the LON is reviewed by the Service Coordinator and the LOC is completed by a QDDP.

Following completion of the annual ISP meeting and no later than thirty (30) days following the meeting, the DDS Service Coordinator's supervisor reviews and approves the ISP. The supervisor is responsible for ensuring that the waiver services are clearly delineated and justified based upon the needs identified in the Plan of Care and its accompanying assessments. The ISP is implemented within thirty (30) days of the ISP meeting. Annually, the entire team meets to review and revise the plan for the upcoming service year.

1) The types of assessments conducted to support the service plan development process include personal interviews, person centered and initial assessments as applicable and completed as part of the intake and eligibility process. Personal interviews are conducted with each individual during the ISP development process. For new enrollees in the waiver, the assessments completed as part of the intake and eligibility process are utilized for the initial planning process. The initial applicable assessments may include medical evaluations, a LON and psychological (where applicable).

2) A reassessment may be conducted at any time, particularly when a significant change in the person's status occurs. The assessment process is ongoing, and designed to reflect changes in the individual's life, needs, and changing personal outcomes, including strengths, needs, preferences, abilities, and resources.

At each annual planning meeting thereafter, the Service Coordinator and team members will review all available assessments person centered and discovery tools indicating what is important to and important for the person and any other support plans in place in preparation for the annual planning process. This will include a review of the completed LON and any other additional risk screening or assessment tools that have been completed.

(a) persons and their legal representatives are informed of available applicable waiver services during the initial planning meeting with the Service Coordinator. Annually, individuals are informed of waiver services available during the ISP development process, and more frequently as needed, should their circumstances or needs change, including their desire to change providers.

(b) The plan development process ensures that the service plan addresses participant outcomes, needs, and preferences by identifying the person's prioritized personal outcomes, and specific strategies needed to achieve and maintain the desired personal outcomes, focusing first on informal and community supports and , if needed, paid formal services.

An action plan shall guide the implementation of strategies to achieve the desired personal outcomes, including individual program plan (IPP) goals, action steps, review dates and the individuals who will be responsible for specific steps and measurable goals, thereby ensuring that the steps incorporated empower and help the individual to develop independence, growth, and self-management. The action plan shall incorporate the target dates for the achievement/maintenance of personal outcomes, the preferred formal and informal service supports and specification of the service arrangements, individuals who will assist the service coordinator in planning, building/implementing supports, or direct services and the verification of signatures from the individual and all team members present indicating their agreement with the ISP. The requirement of this information and its inclusion in the ISP ensures the individual's identified outcomes, needs, and preferences are appropriately addressed.

(c) The plan development process ensures that the service plan addresses participant outcomes, needs, and preferences by identifying the person's prioritized personal outcomes, and specific strategies needed to achieve and maintain the desired personal outcomes, focusing first on informal and community supports and , if needed, paid formal services.

An action plan shall guide the implementation of strategies to achieve the desired personal outcomes, including individual program plan (IPP) goals, action steps, review dates and the individuals who will be responsible for specific steps and measurable goals, thereby ensuring that the steps incorporated empower and help the individual to develop independence, growth, and self-management. The action plan shall incorporate the target dates for the achievement/maintenance of personal outcomes, the preferred formal and informal service supports and specification of the service arrangements, individuals who will assist the service coordinator in planning, building/implementing supports, or direct services and the verification of signatures from the individual and all team members present indicating their agreement with the ISP The requirement of this information and its inclusion in the ISP ensures the individual's identified outcomes, needs, and preferences are appropriately addressed.

(d) Waiver and other identified services in the ISP are coordinated through the Service Coordinator. Service coordinators are required to make monthly contact with each individual, except during months when residential or day monitoring has occured, and conduct a face-to-face visit with the individual on a quarterly basis. During monthly contacts, the service coordinator shall ensure ISP implementation of IPP goals, health treatment plans of support. During four (4) monitoring visits,Service Coordinators review information in the ISP, track progress on identified goals and timelines, and get updated information on the progress of informal/unpaid supports identified in the ISP. A Service Coordination monitoring tool is completed at each of the four (4) monitoring visits. Information from the tool is entered into the DDS Information system.

(e) The plan development process provides for the assignment of responsibilities to implement and monitor the plan as follows:

The person and their legal representatives are encouraged to contact the Service Coordinator at any time for assistance. Monthly contacts offer an opportunity for the individual to request a team meeting to make formal revisions to the ISP, and for the Service Coordinator to request a reassessment or a new assessment.

1) Each goal identified in the ISP has time frame for accomplishment. The Service Coordinator is responsible for monitoring the progress of goals to ensure that they are implemented or to ensure that revisions are made as necessary when identified goals need to change, or cannot be accomplished within the identified time frames.

2) During the development of the ISP, team members are asked to take on roles and responsibilities to facilitate linkage of the individuals and their legal representatives, the Service Coordinator receives information on the progress of these assignments and the success in assisting the individual to enhance or maintain their quality of life.

3) Every six (6) months, or more frequently as needed, the Service Coordinator, the individual, the service provider(s), and others that the individuals chooses to be present, review the ISP to determine if the goals identified in the ISP are being met. They achieve this by reviewing the individual's needs, identifying health and safety measures to ensure identified needs are being addressed, and by making any adjustments or changes necessary to the plan.

(f) The ISP must be revised annually or as necessary to meet the needs of the individual. The Service Coordinator is tasked with contacting the individual to arrange for the scheduling and location of the meeting. The Service Coordinator also contacts the person's service providers to inform them about the meeting. The ISP meeting is always completed before the anniversary date of the current ISP. The Service Coordinator is solely responsible for ensuring that the ISP is conducted in accordance with DDS requirements and is with best practices in the field of developmental disabilities. Mid ISP cycle changes that require ISP revision are coordinated by the Service Coordinator, Documentation for the ISP revision is completed by the Service Coordinator and submitted to the Service Coordinator's supervisor for review and approval. The supervisor has two (2) business days to review and approve the ISP or return it to the Service Coordinator for any necessary, additional information.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☑ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☑ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

☑ **A specific and individualized assessed need for the modification.**

☑ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**

☑ **Less intrusive methods of meeting the need that have been tried but did not work.**

☑ **A clear description of the condition that is directly proportionate to the specific assessed need.**

☑ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**

☑ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**

☑ **Informed consent of the individual.**

☑ **An assurance that interventions and supports will cause no harm to the individual.**

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.

DDS completes the LON at least annually for all persons. The assessment process may include interviews with the person and his/her legal representatives. The Service Coordinator conducts a review of any critical incidents during the preceding year. The completed LON assessment will be reviewed by the person's support team at the time for the initial Individual Support Plan (ISP) meetings and be updated as needed at the time.

During the planning process, team members discuss possible strategies to mitigate potential risks that have been identified. Development of strategies to mitigate risks shall take into account the needs and preferences of the person. The approaches utilized to mitigate each specific risk are incorporated into the ISP.

The emergency back-up plan is a core component of the ISP format and is completed at the time of the planning meeting. All enrolled providers of waiver services must possess the capacity to provide the support and services required by the individual in order to ensure the individual's health and safety as determined by the team and detailed in the ISP. When paid supports are scheduled to be provided by an enrolled provider of waiver services, that provider is responsible for providing all necessary staff to fulfill the health and safety needs of the person, including times when scheduled direct support staff are absent, unavailable, or unable to work for any reason.

The identified enrolled provider of waiver services cannot use the person's informal support system as a means of meeting the person's back-up plan unless the person, with assistance from their team, has agreed to do so. This agreement must be documented in the ISP.

The Service coordinator assists the person and the team members in identifying individuals who are willing and able a back-up system during times when paid supports are not scheduled or unavailable. This information should be documented in the person's ISP.

Back-up plans are updated no less than annually through the ISP process to assure information is kept current and applicable to the person's needs at all times. The identified enrolled provider of waiver services must have policies and procedures in place that outline the protocols that the agency has established to assure that back-up direct support staff are readily available, lines of communication and chain-or-command have been established, and procedures are in place for dissemination of the back-up plan information to individuals, their legal representatives, and the Service Coordinator.

Protocols outline how and when the direct support staff are to be trained in the care and supports needed by the person must also be included. This training must occur prior to any direct service worker being solely responsible for the support of the person.

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.

The person and their legal representatives are informed of all applicable waiver during the Service Coordinator's initial planning meeting with the person. Part of this contact involves a discussion of Freedom of Choice of qualified waiver providers and the availability of services. The Service Coordinator and the person and their legal representatives also discuss the role of the Service Coordinator and determine the support that the person requires from the Service Planning and Coordination Division.
The Service Coordinator provides the person with a list of all qualified Medicaid providers and the specific waiver services they offer. The person and their legal representative are encouraged by the Service Coordinator to interview or visit each provider agency that they are interested in, in order to make informed choices. The Service coordinator is available to assist the person in contacting and interviewing potential providers. The Service coordinator also has the responsibility of assisting the person when they wish to change providers.

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):

Authorities to approve individual centered plans are delegated to DDS, the operating agency. DHCF staff will participate in one Individual Support Plan meeting during the year and review 10% of DDS ISP Quality Review samples to monitor waiver assurance and compliance with the Memorandum of Agreement (MOA) with DDS.

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, when the individual's circumstances or needs change significantly, or at the request of the individual, 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:

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:

Operating agency shall maintain service plans for six (6) years.

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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Service Plan Implementation:

• The Service Coordinator is responsible for monitoring the progress of goals to ensure that they are implemented or that revisions are made as necessary when identified goals need to change, or cannot be accomplished within the identified time frames. Service Coordinators are required to make monthly contact with each individual, and conduct a face-to-face visit and monitoring tool with the individual on a quarterly basis. During four (4) of these monthly contacts, Service Coordinators review information on the ISP, track progress on identified goals and timelines, and get updated information on the progress of informal/unpaid supports identified in the ISP.

• During the development of the ISP, team members are asked to take on roles and responsibilities to facilitate linkage of the person to the identified services and support that are outside of the Medicaid-funded services. During this time, the Freedom of Choice form is completed which documents the person's informed choice regarding accessing services through the HCBS IDD waiver or through an ICF. Freedom of choice is also maintained throughout the service delivery process as changes in providers are needed to address varying support needs.

• Every six (6) months, or more frequently as needed, the Service coordinator, the individual, the service provider(s) and others that the individuals chooses to be present, review the Plans of care to determine if the goals identified in the ISP are being achieved, review the person's needs, including health and safety to ensure identified needs are being addressed, and to make any adjustments or changes necessary to the ISP.

• Service Coordinator supervisors review a sample of ISPs of each of the Service Coordinators whom they do not directly supervise using the ISP Quality Review Tool. The ISP Quality Review Tool is a checklist which examines the ISP cycle, including assessment, development, implementation, monitoring, and modifications. The assigned supervisor reviews the ISP, monitoring tools, notes, incidents, and issues to evaluate service planning and delivery. IT chooses a random sample of waiver individuals, assigns the review to a supervisor who completes the review and provides feedback to the Service Coordinator and their supervisor. The Service Coordinator and supervisor take action to resolve any individual issues discovered. The aggregated results of the ISP Quality Review Tool allows for identification of performance and/or systems issues that can result in corrective action or quality improvement initiatives.

Service Plan Monitoring:
• Service Coordinators are responsible for monitoring service provision in the frequency defined in the policies and procedures. For people receiving waiver services, this is at least four (4) times a year. The monitoring tool includes probes related to satisfaction with professional services (i.e. Occupational Therapy), health care supports (i.e. as defined in the Health Management Care Plan), and the amount of staff (i.e. individualized staffing), behavior supports, and all other services identified in the ISP. When the person is not receiving the services identified, the Service Coordinator can sometimes immediately correct the issue or may enter it as an issue to which the provider must respond and the assigned staff monitors to closure. The aggregated monitoring tool results are analyzed quarterly for patterns with providers and/or services to identify systems improvement activities.

• The SPCD will conduct regular monitoring reviews and contacts for each person who receives supports or services through the DDA service delivery system. Monitoring reviews shall be done in person. At least one review per ISP year may be conducted without the person being present. Monitoring reviews are to be conducted according to scheduled timeframes. However, it is DDA's expectation that service coordinators will conduct additional reviews, phone calls, and monitoring as needed to ensure the person's health, safety, and well-being. Non-waiver services are documented in the participant's Individual Support Plan (ISP). Service Coordinators conduct monthly check-ins and quarterly monitoring which include face to face visits to monitor progress on non-waiver, health services. Service Coordinators also review and follow up on hospitalizations reported in the CRISP system. DDS' Health and Wellness nurse consultants conduct quarterly wellness pone checks to answer any health-related questions, encourage completion of annual physical, related health screenings, and vaccinations. Additionally, the Nurse Practitioner, completes a follow up call to monitor the participant's health status after an emergency room visit as identified by the CRISP report. When a complex health need has been identified, the Nurse Practitioner monitors to ensure the participants are receiving necessary health services.

The supervisory service coordinator conducts sample reviews of ISPs to ensure the completion of the backup plan. The effectiveness of the backup plan is checked through monthly ISP reviews and service coordination monitoring visits.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except,

at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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:
SP.a.i.a.PM.2. Percentage of service plans that address the person's assessed needs (including health and safety risks, and personal goals). N=Number of service plans that address the person's assessed needs (including health and safety risks, and personal goals) / D= Number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ISP Quality Review-MCIS/Applicable DDS electronic information system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DDS will conduct a confidence level review of service plans of 90% and margin of error of 10%.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP.a.i.a.PM.1. The Interdisciplinary Team (IDT) completes the Level of Need and Risk Screening (LON) assessment prior to the development of each individual's Individual Support Plan (ISP). Number of people for whom an LON was completed prior to ISP development (numerator)/Number of people who have an annual ISP completed during the reporting period (denominator).

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCIS/Applicable DDS electronic information system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

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: 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:
SP.a.i.c.PM.1. Percentage of annual ISPs approved on time within 365 days. Annual ISPs approved on time (numerator)/ISPs due (denominator)

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
MCIS/Applicable DDS electronic information system

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP.a.i.c.PM.2. Percentage of ISPs revised when warranted by changes in the person's needs. N= Number of ISP's revised when warranted by changes in the person's needs D= Number of ISP's that warranted a change in needs and/or supports

Data Source (Select one):
Other

If 'Other' is selected, specify:

ISP Quality Review-MCIS/Applicable DDS electronic information system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = DDS will conduct a confidence level review of 90% (10% margin of error) of all ISP's approved per month.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***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:
SP.a.i.d.PM.1. Percentage of people that receive services as described in the ISP in type, scope, amount, duration and frequency. N=Total number of people that receive services as described in the ISP in type, scope, amount, duration and frequency D= Total number of unduplicated people reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Day and Residential Monitoring Tools-MCIS/Applicable DDS electronic information system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

e. ***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.

Performance Measure:
SP.a.i.e.PM.2. Percentage of people whose records have signed evidence of a choice of services and providers. N=Number of people whose records have signed evidence that he/she was offered choice of services and service providers D= Total number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ISP Quality Review-MCIS/Applicable DDS electronic information system

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

		DDS will conduct a confidence level review of 90% (10% margin of error) of all ISP's approved per month.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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.

SP.a.i.a.PM.1. The Interdisciplinary Team (IDT) completes the Level of Need and Risk Screening (LON) assessment prior to the development of each individual's Individual Support Plan (ISP). (Number of individuals for whom an LON was completed prior to ISP development/Number of individuals who has an annual ISP completed during the reporting period)
Monthly data is reported regarding the completion of LONs as scheduled by the service coordinator and supervisor. Remediation is completed via the supervisory process. Quarterly, the data is reviewed and results are discussed for remediation strategies if any and documented as part of the ongoing quality improvement strategies.

SP.a.i.c.PM.1. Annual ISPs are approved on time within 365 days (Annual ISPs approved on time/ISPs due)
Quarterly, the ISP performance data is reviewed to identify any individual or system issues which may result in corrective action and/or quality improvement initiatives.

SP.a.i.a.PM.2. Percentage of service plans that address the person's assessed needs (including health and safety risks, and personal goals). N=Number of service plans that address the person's assessed needs (including health and safety risks, and personal goals) / D= Number of service plans reviewed.

SP.a.i.c.PM.2. Percentage of ISPs revised when warranted by changes in the person's needs. N= Number of ISP's revised when warranted by changes in the person's needs D= Number of ISP's that warranted a change in needs and/or supports.

SP.a.i.e.PM.2. Percentage of people whose records have signed evidence of a choice of services and providers. N=Number of people whose records have signed evidence that he/she was offered choice of services and service providers D= Total number of service plans reviewed.
As part of the ISP Quality Review, the supervisor reviews the ISP, monitoring tools, notes, incidents, and issues to evaluate service planning and delivery, and provides feedback to the service coordinator and their supervisor. The service coordinator and supervisor take action to resolve any individual issues discovered. The aggregated results of the ISP Quality Review Tool allows for identification of performance and/or systems issues which can result in corrective action or quality improvement initiatives.

SP.a.i.d.PM.1. Percentage of people that receive services as described in the ISP in type, scope, amount, duration and frequency. N=Total number of people that receive services as described in the ISP in type, scope, amount, duration and frequency D= Total number of unduplicated people reviewed.

Service Coordinators are responsible for monitoring waiver service provision as defined in policies and procedures. When the person is not receiving the services identified, the Service Coordinator can sometimes immediately correct the issue or may enter it is an issue to which the provider must respond and the assigned staff monitors to closure.

The aggregated monitoring tool results are analyzed quarterly for patterns with providers and/or services to identify systems improvement activities.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Through formal and informal monitoring activities, all DDA staff and contractors identify and report individual and provider

issues by entering them into the Issue Resolution System in MCIS. The Immediate Response Committee (IRC) assigns the issue to the appropriate staff. The assigned staff document activities and closure in MCIS. Issues are tracked with due dates on DDA personnel performance management dashboards and monitored monthly by direct supervisory personnel and quarterly by the DDA Performance Management Meeting process.

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**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

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.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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.

Official introduction to the HCBS waiver program is provided by the DDS Service Coordination and Planning Division. This includes information on the choice between ICF and the HCBS Waiver program. Individuals interested in the DDS/DDA waiver receive information from the assigned DDA Service Coordinator on how to access the DDS provider information from the DDS website, as well as information about the HCBS waiver services. At that time, information regarding the fair hearing process is also provided, including grounds for an appeal, such as denial of a service and disputes that are not reconciled through dialogue with the DDS waiver provider or with DDS. DDS notifies HCBS IDD waiver participants of the opportunity to request a fair hearing in writing, utilizing standard forms, any time the following circumstances occur: (1) the participant is not offered a choice of either institutional care in an ICF/DD or home and community-based services, (2) the participant is denied a waiver service that he or she has requested, (3) a decision or action is taken to deny, suspend, reduce or terminate a IDD waiver-funded service authorized on the participant's ISP, (4) the participant is denied his or her choice of qualified HCBS IDD waiver provider(s), or (5) a decision or action is taken to deny, suspend, reduce or terminate the participant's Medicaid eligibility. Notices of adverse actions and opportunity to request a fair hearing are kept at DDS. The Economic Security Administration (ESA) determines eligibility for DC Medicaid, and sends written notice of the eligibility determination to applicants on a standard form which contains an explanation of the applicant's right to request a fair hearing, regarding Medicaid eligibility. The ESA Case Manager contacts the applicant and discusses the reason for the denial.

Applicants and participants also receive notice of fair hearing rights in actions related to the level of care (LOC) determination. Applicants or participants who do not meet the LOC required for participation in the IDD waiver receive a denial letter from DDS which includes the information on how to access the fair hearing process.

When an agency seeks to discontinue services provided to a participant, the participant must be given 30 days written notice by the agency. The service coordinator is also responsible for assisting the participant in pursuing alternative service providers and any other necessary actions to assure the participant's health and welfare.

A participant who appeals a service decision is informed that services will continue during the period while the participant's appeal is under consideration. If the applicant is not eligible for Medicaid, services will not have started. If a participant is notified of a service termination or suspension, the provider agency continues services while the appeal is processed and until the outcome of the hearing. If needed, alternative arrangements are made for continuation of services. Notification will be made to the participant by the provider agency.

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**

- **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.

Do not complete this item.

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**

• **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

In addition to the right to request a fair hearing with the Office of Administrative Hearings (OAH), DDS operates an internal administrative formal complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver as described below. All requests for fair hearing must be made directly and in writing to the District of Columbia Office of Administrative Hearings. The DHCF Office of the Healthcare Ombudsman can assist applicants or participants in completing and submitting the request for fair hearing to the OAH.

Each person is informed that making a complaint is not a pre-requisite or substitute for a Fair Hearing.

• **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).

The DDS/DDA Formal Complaints System Policy and cross referenced procedures apply to every person who is eligible for and served by DDA and the DDA service providers and outlines the method for persons to file a complaint and seek informal resolution regarding the services of DDA and the service provider. Individuals who want to appeal an eligibility for services decision would utilize the process at the Office of Administrative Hearings (OAH).

a) The types of complaints include, but are not limited to, the denial, delay, reduction or termination of DDA supports or services including Medicaid waiver services (Note: Use of the DDA Formal Complaint System will not change or lengthen the deadline for filing a Medicaid appeal at the D.C. Office of Administrative Hearings (OAH)); The application of DDA policies, procedures or practices to the person; and the application of DDA providers' policies, procedures or practices to the person. Types of Complaints A Person May NOT File in The DDA Formal Complaints System include: 1. DDA initial eligibility appeals. 2. Challenges to pending IMEU investigations or appeals of IMEU investigation reports. 3. Complaints that are currently or have been historically submitted to the OAH.

b) Persons receiving DDA supports and services, or another person on their behalf and with their consent, may file a complaint about the person's DDA supports and services, as long as they do within 90 calendar days from the final day of the event that the person says took place, or did not take place when the person believes it should have, giving rise to the complaint. This time limit applies whether the person's complaint is filed with a DDA provider or with DDA Formal Complaint System. A person may file a formal complaint when an issue is ongoing.
A person may request a waiver of the 90 calendar day filing requirement from the DDS Director, or his or her designee. The request must include the facts the person asserts to support their request for a waiver, and the DDS Director will consider those facts and determine whether to grant the waiver.

c) The DDA Formal Complaint System shall have three stages of review. Stage One shall be Internal DDS Review. Stage Two shall be External Review. Stage Three shall be External Reviewer's Final Report and DDS Director's Final Decision.

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).

DDS Policy and Procedure for Incident Management and Enforcement describes each incident type and reporting requirement. There are two types of incidents-Reportable Incidents (RI) and Serious Reportable Incidents (SRI). Reportable incidents are significant events which require reporting to DDS by the end of the next business day and investigation by the provider. RIs include medication errors, physical injuries, emergency restraints, suicide threats, vehicle accidents, fires, police incidents, emergency room visits, emergency relocations, and property destruction. Serious Reportable Incidents are events that due to severity require immediate response, notification to, and investigation by DDS in addition to the internal review and investigation by the provider agency. SRIs include death, allegations of abuse, neglect or exploitation, serious physical injury, inappropriate use of restraints, suicide attempts, serious medication errors, missing persons and emergency hospitalization. Specific definitions are in the procedures.

All employees, sub-contractors, consultants, volunteers or interns of a provider or governmental agency, are required to make an oral report immediately when a SRI, which requires critical timelines for successful resolution is witnessed, discovered, or becomes known. Notification is made to the DDA Service Coordinator by the provider or other reporter during regular business hours, and the DDA Duty Officer during non-business hours.

All incidents (RIs and SRIs) are reported by the responsible provider or DDA staff to DDS through the MCIS incident management system by the end of the following business day.

SRIs and RIs are reviewed by the Immediate Response Committee (IRC) as described in the Immediate Response Committee (IRC) Policy and Procedure. The IRC evaluates the reported actions taken to ensure the individual's safety and determine if additional actions are warranted, assess the timeliness of the report, assign follow-up and verify that notifications were made in accordance with the Incident Management and Enforcement Procedure.

The Service Coordinator is responsible for follow-up regarding services or unmet needs by telephone or email within two (2) business days of acceptance by the IRC of an SRI excluding a death. Follow-up is documented in the notes section of the individual's record in MCIS.

Deaths are reported as SRIs in accordance with the Incident Management and Enforcement Procedure and the Mortality Reporting Procedure. When a death occurs, the reporter immediately notifies the DDA Service Coordinator during business hours and the Duty Officer after hours. An incident report is also completed by the end of the next business day. The Deputy Director of Quality Assurance and Performance Management Administration (QAPMA) and the Mortality Review Coordinator assess the circumstances around the death and determine the need for immediate follow-up. Sudden or unexpected deaths may result in a desk review by a Health and Wellness Specialist and/or an on-site visit by the Mortality Review Coordinator, Duty Officer, or other assigned staff.

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.

The staff in the Intake Unit provides the applicant and the family and/or guardian a fact sheet about abuse, neglect, and reporting at the time that they are enrolled for services with DDA. The service coordinator also provides a fact sheet about abuse, neglect, and reporting, and facilitates a discussion regarding the individual's risks and support strategies at least once a year. This is documented in the designated section of the ISP (Essential Planning Considerations).

The Incident Management Policy requires each provider to conduct educational activities to individuals regarding the right to be free from abuse and neglect and how to report any allegations of mistreatment. Providers are required to inform all individuals receiving services and their parents or guardians of the policy and procedure for handling incidents. Additionally, all Board members, employees, interns, volunteers, consultants, contractors, as well as advocates should be informed about the policy. The provider also provides telephone numbers for internal emergency contacts as well as proper authorities.

DDS has developed and implemented the DDA Internal Problem Resolution Procedures. At the time of admission and at least at the annual ISP meeting, the individual is informed of his or her right to file a complaint. DDA accepts complaints from individuals served, their family members and/or guardians, friends, attorney, advocate, service provider, DDA staff or any interested person. The complaints are made to the Rights and Advocacy Specialist in person, by phone, email or U.S. mail. The Rights and Advocacy Specialist responds in writing to the complainant within thirty (30) calendar days and includes the individual's right to appeal to the DDS Deputy Director for DDA.

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.

Each business day, the Immediate Response Committee (IRC) reviews each SRI and RI received since the last meeting to evaluate the effectiveness and appropriateness of the action taken by the provider in response to the incident. An action is deemed appropriate when the IRC determines that the actions taken are likely to ensure the individual's safety. If appropriate action was not taken the IRC Facilitator informs the assigned service coordinator and/or the IMEU investigator who conducts follow-up activities. The IRC action is documented in the notes section of MCIS for the related incident.

The Service Coordinator is responsible for conducting follow-up regarding services or unmet needs by telephone or email within two (2) business days of acceptance by the IRC of an of an SRI excluding death. Follow-up is documented in the notes section of the individual's record in MCIS.

For SRIs involving an allegation of abuse or neglect or a serious physical injury, the IMEU investigator conducts an in-person visit within three (3) business days of assignment, or by 5 p.m. on the day following a weekend or holiday, unless waived by the supervisory investigator.

For SRIs involving an investigation, the responsible provider investigates each RI and SRI reported. For RIs the provider is required to review and investigate the incident within five (5) business days. This investigation may be an abbreviated investigation based upon the initial assessment by the provider. All documented evidence as well as a summary of the findings and conclusions must be maintained at the individual's home or service location for review by DDS or other government entities during monitoring visits. Depending on the initial findings, the provider may complete a full investigation or be requested to complete a full investigation by DDS (based on the summary or data collected from other DDA divisions). The report must be available for review at the individual's home or service location during monitoring visits and must be submitted to DDS within three (3) business days if requested. For SRIs (except deaths) the provider is notified of the assignment and works with the DDS investigator to complete the investigation and ensure the person is safe. DDS completes investigations of all other SRIs in conjunction with the provider within forty-five (45) calendar days. The provider is responsible for informing the person of the investigation outcomes.

All providers and DDS Investigators assigned to conduct investigations of SRIs must complete and pass an investigatory competency-based training course. Staff who have not completed and passed a competency-based training may assist in investigations of RIs and SRIs assigned to a certified investigator. The completed investigation report must include a description of the role and activities of any non-certified investigator. The certified investigator is responsible for all investigation activities and must sign off on the investigation. When DDS makes recommendations in response to the investigation, the DDA Incident Management and Enforcement Unit (IMEU) staff shall ensure that recommendations are implemented and reported in MCIS.

In the event of sudden or unexpected death, the Health and Wellness staff may conduct a desk review and the Mortality Review Coordinator or designee may conduct a Safety Assessment at the discretion of the Deputy Director of the Quality Assurance and Performance Management Administration (QAPMA) and based on the Mortality Reporting Procedure. The Mortality Review Coordinator or designee conducts a site visit to the individual's place of death or home unless the person was hospitalized for an extended period or lived independently or with family (i.e. natural home) by the close of the next business day unless the person is outside of the District of Columbia metro area or there are other unusual circumstances such as severe weather.

All deaths are investigated. DDS maintains a contract with an outside expert to conduct an independent investigation. The investigation report is due within forty-five (45) business days of receiving a complete record in accordance with the Mortality Reporting Procedure. The Mortality Review Committee reviews the investigation within forty-five (45) days of receipt and makes recommendations to the provider and/or DDS. The recommendations for DDS are tracked by the Mortality Review Coordinator and recommendations for the providers are tracked by designated Quality Management Division staff. The Mortality Review Coordinator submits all final investigation reports to the District of Columbia Fatality Review Committee in accordance with the 2009 Mayoral Order (Revitalization-District of Columbia Development Disabilities Fatality Review Committee, Mayors Order 2009-225, Dec. 22, 2009). When the District's Fatality Review Committee (FRC) makes recommendations to DDS, the department will respond within the required time frame.

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.

The Immediate Response Committee (IRC) conducts a preliminary assessment of each RI and SRI. During daily meetings, the IRC members use MCIS to review the incident history of the person. If the committee identifies a pattern, the IRC Facilitator or designee will enter an incident or issue in accordance with the established policies and procedures for incident and issue management.

The IRC Core Team meets monthly to review historical data to include frequency,types of incidents and other variables to identify individual and/or provider patterns or trends. If the committee suspects there is a pattern the IRC Core Team Facilitator or designee will research the concern and report back to the IRC Core Team. When the committee identifies a pattern, the IRC Core Team Facilitator or designee will enter an incident or issue in accordance with the established policies and procedures for incident and issue management.

Each quarter, the Quality Assurance and Performance Management Administration (QAPMA) Director designates a person to prepare a summary report for the committee to review, analyze, and make recommendations regarding incident management. The quarterly report is submitted to DHCF.

Significant findings are reviewed by the DDA Quality Improvement Committee who makes recommendations to the DDS Deputy Director for DDA, for providers and/or systemic follow up.

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 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).

It is the policy of DDS, as described in the Human Rights Policy, to ensure that people with intellectual disabilities are supported with the most proactive, least restrictive and effective interventions and to ensure that behavioral supports, which include restrictive controls, are reviewed and approved by the person and/or guardian/substitute decision maker, their ISP Team, the provider's Human Rights Committee, and the DDS Human Rights Advisory Committee or the DDS Restrictive Control Review Committee.

DDS prohibits the use of seclusion or secured time-out rooms and mechanical restraints. A mechanical restraint is defined as an apparatus used to restrict individual movement such as straight jackets, shackles, or belted jackets which cannot be removed by the person. However, mechanical supports including those used to achieve proper body position or balance and protective devices for specific medical conditions or behavior (i.e. helmet to protect a person from falls or a mitt used to protect a person from injuring him/herself), shall be used when approved by a physician. DDS also prohibits the use of prone restraints or other restraints that restrict breathing, restraints that utilize a face-down position, restraints that secure a staff person on top of the individual; restraints that rely on the infliction of pain for control; restraints that involve any take-down technique in which the individual is not supported and is encouraged to free fall as they drop to the floor or other surface. DDS also prohibits the use of a psychotropic medication in response to a problematic behavior which impairs the individual's ability to engage in his or her activities of daily living by causing disorientation, confusion, or impairment of physical or mental functioning.

Formal monitoring is conducted for each person receiving waiver services. Inappropriate use of a restraint is a SRI and requires immediate reporting. All DDA employees, sub-contractors, providers/vendors, consultants, volunteers and governmental agencies funded by DDS or the DHCF that provide supports and services to individuals receiving services as part of the DDS service delivery system are required to report all inappropriate use of restraints. Each incident is investigated and recommendations are followed to resolution by the Incident Management and Enforcement Unit (IMEU).

DDS allows the use of restrictive interventions on a limited basis after less restrictive interventions to safeguard people and property have failed or if there is no time to attempt less restrictive methods for the following purposes: when an individual's health or safety is at risk; when court-ordered; as a health related protection ordered by a physician; if absolutely necessary during the conduct of a specific medical or surgical procedure; or for the individual's protection during the time that a medical condition exists, as a means to protect a person or others from harm, or as a means to prevent the destruction of property.

It is the policy of DDS, described in the Human Rights Policy, to ensure that all people receiving waiver services are treated with psychotropic medication for mental health needs consistent with national standards of care as described in the Health and Wellness Standards. Psychotropic medications may only be used after a thorough psychiatric evaluation by a licensed health care provider. Psychotropic medications may be prescribed to correspond with known standards of effectiveness related to the specific diagnosis, symptom or behavior. Individuals must be monitored for medication side effects using a standardized tool (i.e. AIMS or DISCUS) to ensure that the person receives the fewest psychotropic medications as possible at the lowest effective dosage and that the use of psychotropic medication is regularly reviewed by the prescribing licensed health care provider consistent with the Health and Wellness Standards.

The Service Coordinator conducts monitoring to ensure that people who use psychotropic medications have quarterly medication reviews with the psychiatrist and that there is an every six month screening for medication side effects using a standardized tool (i.e. AIMS or DISCUS).

The Health and Wellness staff conducts Health Care Reviews for a sample of people in the waiver services outside of their natural home as part of the routine Health and Wellness monitoring activities. These reviews are assigned by the Health and Wellness Supervisory Community Nurse, and can also be requested at any time by a Service Coordinator in response to any specific concerns. The Health and Wellness staff monitors the provider's adherence to the Health and Wellness Standards.

When a person, not in his or her natural home, is receiving psychotropic medications and the provider is not adhering to the Health and Wellness standards, DDA's staff person, who has knowledge, follows the Immediate Response Committee (IRC) Policy and Procedure to report issues and/or the Incident Management and Enforcement Policy and Procedure to report incidents. These issues and incidents are

followed through the standard practices already described in other sections in this appendix (Appendix G).

Consistent with national standards of care, as described in the Behavior Support Policy and Procedure, it is the policy of DDS to ensure that all behavior support plans are developed by a qualified clinician and identifies any use of restrictive controls, including psychotropic medication, individualized staffing or physical interventions. In order to ensure that psychiatric and behavior interventions are used in accordance with standards of medical and behavior health practice, DDS/DDA requires safeguards for the use of psychotropic medications and behavior supports that include the use of restrictive control interventions.Proper procedures and standards established to promote positive behavior supports are person-centered and person-centered trauma-informed. Behavior support plans should be ethical in design and delivery, while demonstrating respect for the person and protecting his/her rights and freedoms, based on an understanding of the person and the function of the behaviors as described in the Behavior Support Policy and Procedure

Methods for detecting unauthorized use, over use or inappropriate/ineffective use of restraints or seclusion and ensuring that all applicable state requirements are followed?
During routine monitoring by Service Coordinators which occurs at least four times per year (one time per quarter) for each person receiving waiver services, the Service Coordinator meets with the person, the staff and reviews documentation to detect unauthorized use of restraints or seclusion or overuse of approved restraints. Seclusion is not allowed and therefore, any use would be unauthorized. Any unauthorized use of restraint or seclusion would result in an incident of inappropriate use of restraint or neglect. All allegations of neglect are investigated by DDA's IMEU (Incident Management and Enforcement Unit) Investigators.

Health Care Review Summaries are completed by Health and Wellness Specialists. The Health and Wellness Supervisor determines the number of reviews to be completed each fiscal year. Each year DDA Nurse Consultants will conduct a review of 25% of the total number of people who receive residential services in the District of Columbia, by provider, regardless of funding authority.

The Specialist monitors the use of restraint by meeting the person, the staff and reviewing documentation. Any unauthorized use of restraint or use of seclusion would result in an incident of inappropriate restraint or neglect. All allegations of neglect are investigated by DDA's IMEU Investigators.

The Provider Certification Review (PCR) Team conducts an annual review for each provider which includes a sample of people they serve. If at the conclusion of the PCR any unauthorized use of restraint or seclusion not already reported would result in an incident of inappropriate use of restraint or neglect. All allegations of neglect are investigated by DDA's IMEU investigators.

How data are analyzed to identify trends and patterns and support improvement strategies?
Data from the Service Coordination monitoring, the Health Care Review Summaries, PCR reviews, and from incident reports are reviewed at least quarterly by the QAPMA to identify trends or patterns and make recommendations to the Quality Improvement Committee (QIC) or DDS/DDA management.
The Provider Certification Review (PCR) Team compiles annual reports of data which are reviewed by the Quality Improvement Committee (QIC) who is charged with making recommendations to the Director of DDS, DDS Deputy Director of DDA or the Deputy Director of QAPMA for improvement.

QAPMA compiles a quarterly report of significant findings of all incidents to identify patterns or trends among individuals or by providers. The quarterly report is reviewed by the QIC who is charged with making recommendations for improvement.

QAPMA also compiles a quarterly report of Service Coordination monitoring tools to identify patterns or trends within the service delivery system. The QIC reviews significant findings from the quarterly report and is charged with making recommendations for improvement.

The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence?
Quarterly, QAPMA reviews the incident management system and completes a quarterly report. The data for this report is drawn from DDA's Electronic Information System (MCIS), which includes demographic

information for every person receiving DDA services as well as up-to-date information about the supports received and their health and well-being. Information is entered into this system through a number of sources, including support staff, Service Coordinators (SCs), the Incident Review Committee (IRC), Investigators, and Compliance Specialists.

The data presented in the quarterly report is primarily descriptive. The goal is to paint a picture of how people receiving DDA services experience SRIs or RIs and show DDA's response to ensure the safety and well-being of each person. The data will also give rise to areas that need improvement and the report will close with recommendations for the next quarter and beyond.

In the quarterly report, the data analysis is broken out in the following way:
Demographic analysis
Overview of SRIs and RIs for all people receiving services from DDA
o By person
o By funding source (Waiver/Non-Waiver)
o Reporting on time
o Investigation Outcomes for SRIs
o Incident Recommendations
o Recommendations for further action
Significant findings from this report are reviewed by the Quality Improvement Committee (QIC) who is charged with making recommendations for quality improvement to the Director of DDS, the DDS Deputy Director for DDA or the Deputy Director QAPMA.

Each provider and their staff are required to undergo extensive training on DDS policy regarding the use of approved and prohibited restraints. In addition, the mandatory Behavior Support Plan (BSP) template includes a section where the use of restraints, CPI or MANDT, is discussed to include which techniques should be used when a specific behavior occurs. The BSPs are reviewed by the Restrictive Control Review Committee (RCRC) on an annual or biannual basis dependent on the length of the previous RCRC approval. Lastly, all direct support personnel working with anyone with a BSP are trained on all aspect of that person's specific BSP including the use of approved restraints.

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:

DDS uses information gathered through the Restrictive Control Review Committee (RCRC), service coordination monitoring, health and wellness monitoring, and incident management systems to monitor the effectiveness of the system to ensure that people with intellectual disabilities are supported with the most proactive, least restrictive, and effective interventions.

Service Coordinators conduct monitoring quarterly for persons receiving waiver-funded services. Health and Wellness staff conducts periodic monitoring to measure the system effectiveness. The Provider Certification Team ensures that providers subject to PCR review are following the DDS policies and procedures. When there are individual or provider concerns, the issues are reported through the Issue Resolution System in MCIS are tracked to resolution.

The RCRC reviews all behavior support plans that include restrictive controls to ensure that the support plan was developed in accordance with the policies and procedures of DDS. When there are individual or provider issues, the Rights and Advocacy Specialist who chairs the RCRC follows the Immediate Response Committee Policy to document issues that are tracked to resolution.

Each quarter, the Quality Assurance and Performance Management Administration (QAPMA) Director designates a QIS (staff person) to prepare a summary report of issues related to safeguarding the rights of people served by DDS/DDA. The report is based on monitoring reports and reviews of Behavior Supports Plans completed by the DDS Restrictive Control Review Committee (RCRC). The DDS Rights and Advocacy Specialist provides a report of BSP recommendations from the RCRC reviews to the QAPMA Deputy Director for use in the development of the summary report. The Quality Improvement Committee reviews the summary report and based on their analysis makes recommendations to the DDS Deputy Director for DDA.

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:

● **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.

As described in DDS' Human Rights policy, individuals with a behavior support plan that includes the use of restrictive controls, including psychotropic medication, individualized staffing or physical interventions is performed in accordance with national standards of care as described in the Behavior Support Policy and Procedure. In order to ensure that psychiatric and behavior interventions are used in accordance with standards of medical and behavior health practice, DDS/DDA requires safeguards for the use of psychotropic medications and behavior supports that include the use of restrictive control interventions. As described in the Behavior Support Policy and Procedure, proper standards that are ethical in design and delivery have been developed to promote the use of positive behavior supports. These standards demonstrate an understanding of the individual and the function of the behavior support while simultaneously respecting the individual and the protecting his/or her rights and freedoms.

DDS only allows the use of restrictive interventions on a limited basis after less restrictive interventions to safeguard people and property have failed. Restrictive interventions will also be used if there is no time to attempt less restrictive methods for the following purposes: when an individual's health or safety is at risk, when court-ordered, as a health related protection ordered by a physician, if absolutely necessary during the conduct of a specific medical or surgical procedure, or for the individual's protection during the time that a medical condition exists, as a means to protect a person or others from harm, or as a means to prevent the destruction of property.

The Behavior Support Policy and Procedure establishes the standards, guidelines, provider responsibility, protocols and procedures to be used in providing behavior supports. Behavior support is a service provided in situations where a person with an IDD is determined to have patterns of behavior which are likely to seriously limit or deny access to ordinary community experiences and activities or which threaten the physical safety of the person or others. The procedures require a measurable operational definition of each target behavior; consideration or relevant factors that may influence the target behavior, including but not limited to medical/psychiatric, social, environmental and communication factors; functional assessment of the target behaviors; description of alternative behaviors and replacement skills, and training requirements specific to the behavior support plan. The Behavior Support Plan must describe the use of any restrictive interventions and a plan for reducing, fading or eliminating the use of restrictive interventions. The Behavior Support Plan must provide a rationale for the use of the restrictive intervention including the determination that the restrictive interventions were reviewed against the dangers of the behavior and the restrictiveness of the intervention. There must be sufficient behavior data to demonstrate the need and the effectiveness of the restrictive intervention.

The Behavior Support Procedure also details the requirements when medication is used as sedation prior to medical appointments. A desensitization plan is required unless it is clinically determined that such a plan is ineffective. The use of medication as a sedation requires the same safeguards and approvals as any other restrictive intervention.

The person and/or legal guardian must give informed consent for the use of all restrictive components of the Behavior Support Procedure. Consent must be given by someone legally authorized to do so under District of Columbia laws. Prior to implementation of the BSP which includes restrictive interventions, the BSP must be reviewed and approved by the ISP Team, the provider's human rights committee and the DDS Restrictive Control Review Committee.

During routine monitoring by Service Coordinators which occurs at least four times per year (one time per quarter) for each person receiving waiver services, the Service Coordinator meets with the person, the staff and reviews documentation to detect unauthorized use of restraints or seclusion or overuse of approved restraints. Seclusion is not allowed and therefore, any use would be unauthorized. Any unauthorized use of restraint or seclusion would result in an incident of inappropriate use of restraint or neglect. All allegations of neglect are investigated by DDA's IMEU (Incident Management and Enforcement Unit) Investigators.

Health Care Review Summaries are completed by Health and Wellness Specialist Nurse Consultants. The Health and Wellness Supervisor determines the number of reviews to be completed each fiscal year. In FY2017 DDA Nurse Consultants will conduct a review of 20% of the total number of people who receive residential services in the District of Columbia IDD HCBS waiver, by provider. For example, if an organization provides residential services to 100 people, the Health and Wellness Specialist Nurse

Consultant will complete a Health Care Review for 20 people in that organization. The Specialist monitors the use of restraint by meeting the person, the staff and reviewing documentation. Any unauthorized use of restraint or use of seclusion would result in an incident of inappropriate restraint or neglect. All allegations of neglect are investigated by DDA's IMEU Investigators.

The Provider Certification Review (PCR) Team conducts an annual review for each provider. The PCR team evaluates whether (for the people in their sample) any use of restraint is used in compliance with DDS policy and procedures. If at the conclusion of the PCR any unauthorized use of restraint or seclusion not already reported would result in an incident of inappropriate use of restraint or neglect. All allegations of neglect are investigated by DDA's IMEU investigators.

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:

DDS uses information gathered through the Restrictive Control Review Committee (RCRC), service coordination monitoring, health and wellness monitoring, and incident management system to monitor the effectiveness of the system to ensure that all behavior support plans have been reviewed and approved by the appropriate people and committees.

Service Coordinators conduct monitoring at least once each quarter. Health and Wellness staff conducts periodic monitoring as assigned to measure the system's effectiveness. The Provider Certification Team ensures that providers subject to PCR are following the DDS policies and procedures. When there are individual or provider concerns, the issues are reported through the Issue Resolution System in MCIS and tracked to resolution.

The RCRC reviews all behavior support plans that include restrictive controls to ensure that the behavior support plan was developed in accordance with the policies and procedures of DDS. It is not approved unless there is evidence that the plan contains all required components including consent and review by the provider human rights committee. When there are individual or provider issues the Rights and Advocacy Specialist who chairs the RCRC committee follows the Immediate Response Committee policy to document issues that are tracked to resolution.

Each quarter, the Quality Assurance and Performance Management Administration (QAPMA) Director designates a QIS staff person to prepare a summary report of issues related to safeguarding the rights of people served by DDS/DDA. The report is based on monitoring reports and reviews of Behavior Supports Plans (BSP) completed by the DDS Restrictive Control Review Committee (RCRC). The DDS Rights and Advocacy Specialist provides a report of BSP recommendations from the RCRC reviews to the QAPMA Director for use in the development of the summary report. The Quality Improvement Committee reviews the summary report and based on their analysis makes recommendations to the DDS Deputy Director for DDA.

When oversight is not performed by the Medicaid agency or the operating agency (if applicable), the process for the oversight agency to communicate information and findings to the Medicaid agency and/or operating agency?
DDS is the operating agency and communicates the findings to the Medicaid agency (DHCF) by providing DHCF access to the electronic record system (MCIS) so that DHCF can review data at their discretion. DDS provides quarterly reports of monitoring, copies of completed reports (e.g. Incident Management and Service Coordination Monitoring) and routine conference calls to discuss progress and/or challenges with demonstrating compliance with the assurances.

How is data analyzed to identify trends and patterns and support improvement strategies?
DDS/DDA analyzes the data as described above. DHCF provides oversight by conducting monitoring in accordance with the monitoring plan. As part of an agreement in place with DDS, DHCF was provided access to the DDS incident management system. DHCF's Long Term Care Division reviews data in the incident management system, and incident management data reports from DDS. DDS' incident management reports include several indicators related to incident date, and incident type. Considering that these reports are bi-weekly and can limit DDD' ability to identify systemic issues or trends, DDS uses all reports received and on a quarterly basis performs a comparison analysis. Based on this analysis, DDS prepares a quarterly report which includes trends, findings and recommendations. This report is submitted to DHCF on a quarterly basis.
Additionally, DHCF's Long Term Care Division staff performs monitoring visits and record reviews at individual provider sites. Information gathered during these monitoring visits are reviewed to determine if there are any immediate safety and health concerns. If it is determined that there are immediate safety concerns, depending on the concern, DHCF makes immediate email or telephone contact with DDS. As well, DHCF may prepare a Discovery/Remediation Form for DDS which typically requires DDS to submit a corrective action plan.

The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence?
On a bi-weekly and quarterly basis DDS submits incident management data and quarterly reports, respectively, to the State Medicaid Agency. Upon review of this data, DHCF's assigned staff person from its

Division of Special Needs review the data to identify trends or immediate concerns. If an immediate concern is discovered DHCF prepares a Discovery/Remediation Form and submits the form DDS within five(5) business days of identifying the issue. This Form was developed by DHCF as a strategy for assuring that immediate concerns identified while DHCF performs oversight activities are immediately remediated. In addition to preparing Discovery/Remediation Forms, DHCF prepares quarterly progress reports for review/discussion with DDS. The progress report includes DHCF's analysis of data, findings, and recommendations. Additionally, during monthly quality management committee meetings with DDS there is ongoing discussion regarding individual/systemic problems which can lead to the need for DDS to provide DHCF with a Opportunities for Improvement Plan (OFIP). The quality management committee meetings are also used to discuss the need for DDS to follow up on outstanding issues and to discuss the effectiveness of corrective measures that may have been implemented.

DDS monitors the use of psychotropic medications through Quarterly Psychotropic Medication Reviews (PMR) and that Service Coordination and DDS Nurse Consultants monitor PMRs in their reviews and enter issues if the PMR is not consistent with DDS Policy and Procedures

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:

  Seclusion is expressly prohibited by the DDA Human Rights policy. DDA regularly conducts monitoring in people's home and day and vocational programs in accordance with the DDA Service Coordination Monitoring policy and procedure. Both the Human Rights and Service Coordination policies and procedures are available on-line at: http://dds.dc.gov/page/policies-and-procedures-dda.

- ( ) **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)*

- **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.

The Health and Wellness Standards, specifically Standard Seventeen (17), describes the expectations for Medication Prescription and Administration. The standards require the supervisory registered nurse to review all practitioner's orders, medication administration record (MAR) and medication intervals for all people in the waiver on a monthly basis.
During routine quarterly monitoring, the service coordinator confirms that the person is receiving medication as ordered by the physician. The Health and Wellness staff and Provider Certification Review staff are responsible for monitoring the implementation of the Health and Wellness Standards. The Health and Wellness staff conducts periodic reviews as assigned by the Health and Wellness Supervisory Community Nurse. Providers subject to certification by the Provider Certification Team require annual certification. The use of psychotropic medication is also monitored as described in an earlier section of this Appendix.

Methods for conducting monitoring?
During routine monitoring by Service Coordinators which occurs at least four times per year (one time per quarter) for each person receiving waiver services, the Service Coordinator meets with the person, the staff and reviews documentation to assess that medication is administered as ordered and practices are consistent with DDS policies and procedures. If the practices are not consistent with DDS policies and procedures, an issue will be entered into the electronic record system (MCIS), and assigned to the Health and Wellness Specialist or other appropriate staff for further evaluation and action.
Health Care Review Summaries are completed by the DDA Health and Wellness Specialists. The Health and Wellness Supervisor determines the number of reviews to be completed each fiscal year. Each year DDA Nurse Consultants will conduct a review of 25% of the total number of people who receive residential services in the District of Columbia, by provider, regardless of funding authority. For example, if an organization provides residential services to 100 people, the Health and Wellness Specialist will complete a Health Care Review for 25 people in that organization. The Specialist monitors the provider's compliance with the Health and Wellness standards and other related DDS policies and procedures. The Health and Wellness Specialist provides technical assistance, enters issues into MCIS, and follows up on issues assigned to them.
The Provider Certification Review (PCR) Team conducts an annual review for each provider. The PCR team evaluates whether (for the people in their sample) medications are administered in accordance with established policies and procedures. The PCR Team assesses the organizational systems for adherence to policies and procedures, including staff training. If at the conclusion of the PCR there are any outstanding issues, the issue is entered and assigned to appropriate DDA staff for follow-up.

How monitoring has been designed to detect potentially harmful practices and follow-up to address such practices?
If the practices are not consistent with DDS policies and procedures, an issue will be entered into the electronic record system (MCIS), assigned to the Health and Wellness Specialist or other appropriate staff for further evaluation and action. The Health and Wellness Specialist provides technical assistance, enters issues into MCIS, and follows up on issues assigned to them. If at the conclusion of the PCR there are any outstanding issues, the issue is entered and assigned to appropriate DDA staff for follow-up.

In addition, annually for residential and day service providers, the Quality Resource Unit (QRU) holds a Provider Performance Review (PPR).The QRU solicits input from Service Coordination, Health and Wellness, and Provider Certification Review (PCR) from the results of monitoring. The Quality Assurance and Performance Management Administration (QAPMA) aggregates the data from the Issue Resolution System (IRS) for the PPR identifying those domains and sub-domains where the provider has had issues reported during the past year. When there are recognized patterns or trends, the provider and DDA collaboratively identify quality improvement goals and strategies to minimize the likelihood of repeat or continued problems.

For waivers that serve individuals with cognitive impairments or mental disorders, how second-line monitoring is conducted concerning the use of behavior modifying medications?

The monitoring completed by Service Coordinators and Health and Wellness Specialists is supplemented by the reviews of the use of behavior modifying medications by the Restrictive Control Review Committee (RCRC) and the ISP Quality Reviews completed by Service Coordination Supervisors. The RCRC reviews the use of behavior modifying medications through the review of BSPs that include psychotropic medications. In addition ISP Quality Reviews are completed for a sample of ISPs and the Supervisors review the work of the Service Coordinator in monitoring the use of behavior modifying medications.

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.

DDS and the Department of Health (DOH) review medication management during review processes. DDS reviews the providers' compliance with the Health and Wellness Standards and other applicable policies, procedures, and rules as part of the Provider Certification Review (PCR). DDS monitors the Incident Management System to identify any patterns of individual or provider issues related to the safe administration of medication during the regular Immediate Response Committee (IRC) meetings.

DOH licenses group homes pursuant to section 946 of Title 29 of the DCMR, Chapter 35. Deficiencies in any area are reported to DDS. The DDS Quality Resource Unit reviews the licensing report and enters any issues for follow up into the Issue Resolution System for tracking and follow up.

Significant findings from this report are reviewed by the Quality Improvement Committee (QIC) who is charged with making recommendations for quality improvement to the Director of DDS, the DDS Deputy Director for DDA or the Deputy Director of the Quality Assurance and Performance Management Administration (QAPMA).

How state monitoring is performed and how frequently?
DDS is the operating agency and communicates the findings to the Medicaid agency (DHCF) by providing DHCF access to the electronic record system (MCIS) so that DHCF can review data at their discretion. DDS provides quarterly reports of monitoring, copies of completed reports (e.g. Service Coordination Monitoring) and routine conference calls to discuss progress and/or challenges with demonstrating compliance with the assurances.

DHCF, Division of Long Term Care staff performs monitoring visits and record reviews at individual provider sites. Information gathered during these monitoring visits are reviewed to determine if there are any immediate safety and health concerns. If it is determined that there are immediate safety concerns, depending on the concern, DHCF makes immediate email or telephone contact with DDS. As well, DHCF prepares a Discovery/Remediation Form for DDS which typically requires DDS to submit a corrective action plan.

In addition to preparing Discovery/Remediation Forms, DHCF prepares quarterly progress reports for review/discussion with DDS. The progress report include DHCF's analysis of data, findings, and recommendations. Additionally, during monthly quality management committee meetings with DDS there is ongoing discussion regarding individual/systemic problems which can lead to the need for DDS to provide DHCF with a Corrective Action Plan (CAP). The quality management committee meetings are also used to discuss the need for DDS to follow up on outstanding issues and to discuss the effectiveness of corrective measures that may have been implemented.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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)*

• **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).

The Health and Wellness Standards require that only qualified staff administer medications to people who receive assistance to administer medications during the provision of waiver services. Qualified staff includes registered nurses, licensed practical nurses and trained medication employees.

Medication Administration is governed by DC Municipal Regulations Title 17, Chapter 61. The Board of Nursing (BON) developed a policy, training curriculum and certification that provides for administration by direct support staff. Staff who seek certification to administer medications in the District must be certified in CPR and First Aide, have one year of experience and pass a medication administration course approved by the DC BON. The candidate must provide evidence of a police clearance. The successful Trained Medication Employee (TME) must pass a written test with 80% accuracy and a practicum with 100%. The supervising registered nurse must delegate authority to the staff to administer medications.

TMEs are supervised by registered nurses (RN) on an ongoing basis. The RN will be available to the TME for general or direct supervision. The supervision will be provided in accordance with the BON's certification program.
For people receiving services who were placed by DDS outside of the District of Columbia, medication administration is governed by the state in which the person receives services.

Medication Administration Records (MAR) are required when staff administered medication to a person while the person is receiving services through the waiver. The MAR must include the medication name, dosage, time of administration and signature and title of the person(s) who administered the medications. If medication errors occur, the nature of the error is documented in MCIS as a serious reportable or reportable incident. PRN (Pro Re Nata) medications must be documented on the MAR and include the name and dosage, the time administered. The reason for use and effectiveness of the medication should be noted in a note including a follow up entry to document the medication's effectiveness. Medications are stored in original pharmacy containers which are kept in a locked cabinet or secured in the refrigerator as applicable. Non-oral medications are stored separately from oral medications.

When a person indicates a desire and has the skills, they may administer their own medications. DC Code 21-1201 requires an assessment by a registered nurse to include a determination of the frequency of review/reassessment. A basic record of medication documentation is maintained in the individual's home when the person self-administers medications. Direct care staff may not administer medication but may provide support to remind the person when medications should be taken.

Health and Wellness Standard 18 addresses Psychotropic Medication. A licensed board-certified psychiatrist must make all decisions. Psychotropic medications are prescribed when the person has a formal psychiatric assessment with an Axis 1 diagnosis. The use must be incorporated into the behavior support plan. Psychotropic medications must be renewed by a physician or nurse practitioner every thirty days.

Psychotropic medications may be used for non-psychiatric purposes(i.e. Alzheimer's or dementia, sleep, cerebral palsy or neurodegenerative disorders or as part of a palliative plan to support the person through the end of life as indicated in the Restrictive Controls Review Committee Procedure).

The use must be incorporated into the behavior support plan per the BSP related policy and procedures.

- **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:

All medication errors are reported to DDS in accordance with the Incident Management and Enforcement Procedure. Serious Medication Errors are those that require observation and /or treatment by a physician, physician's assistance or nurse practitioner in a hospital, emergency room or treatment center or patterns or trends of other medication errors that my not require observation and/or treatment but constitute sustained, prolonged or repeated error that may have place the person at risk may be considered neglect. Serious Medication Errors must be reported to the Service Coordinator or Duty Officer immediately with an incident report into MCIS by the end of the next business day. If the person is receiving services in a District licensed group home the error must be reported by the provider to DOH/Health Regulatory and Licensing Authority (HRLA). If the error is made by a TME the provider must report the error to the DOH.

Medication errors that are not serious, that is, any medication error that does not require professional medical attention e.g. missed dosage, medication administered at the wrong time, or documentation error must be reported to DDS through MCIS by the end of the next business day, to HRLA if the person lives in a District licensed group home and if the error is made by a TME to the DOH.

If the person receives services outside of the District of Columbia and was placed there by the DDS, the provider must report the error in accordance with the laws in that jurisdiction in addition to reporting to DDS.

(b) Specify the types of medication errors that providers are required to *record:*

All medication errors are recorded in MCIS in accordance with the Incident Management and Enforcement Procedure. Serious Medication Errors are those that require observation and /or treatment by a physician, physicianÂs assistance or nurse practitioner in a hospital, emergency room or treatment center or patterns or trends of other medication errors that my not require observation and/o r treatment but constitute sustained, prolonged or repeated error that may have place the person at risk may be considered neglect.

Medication errors that are not serious, that is, any medication error that does not require professional medical attention e.g. missed dosage, medication administered at the wrong time, or documentation error must be recorded in MCIS.

(c) Specify the types of medication errors that providers must *report* to the state:

All medication errors are reported to DDS in accordance with the Incident Management and Enforcement Procedure. Serious Medication Errors are those that require observation and /or treatment by a physician, physician's assistance or nurse practitioner in a hospital, emergency room or treatment center or patterns or trends of other medication errors that my not require observation and/or treatment but constitute sustained, prolonged or repeated error that may have place the person at risk may be considered neglect. Serious Medication Errors must be reported to the Service Coordinator or Duty Officer immediately with an incident report into MCIS by the end of the next business day. If the person is receiving services in a District licensed group home the provider must report errors to DOH/Health Regulatory and Licensing Authority (HRLA). If the error is made by a TME, the provider must report to the DOH.

Medication errors that are not serious, that is, any medication error that does not require professional medical attention e.g. missed dosage, medication administered at the wrong time, or documentation error must be reported to DDS through MCIS by the end of the next business day, to HRLA if the person lives in a District licensed group home and if the error is made by a TME to the DOH. The provider is responsible for notifications and must report in accordance with the standards established by HRLA and DOH.
If the person receives services outside of the District of Columbia and was placed there by the DDS, the provider must report the error in accordance with the laws in that jurisdiction in addition to reporting to DDS.

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:

- **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.

During routine monitoring by Service Coordinators, periodic monitoring by Health and Wellness staff, the annual Provider Certification Review, and annual licensing reviews by the Department of Health, individual records are reviewed to ensure all medication errors are reported. The Provider Certification and Department of Health also review the provider's system for medication administration and incident management. Issues or incidents are entered in accordance with established procedures by DDS.

The Immediate Response Committee (IRC) conducts a preliminary assessment of each medication error. During daily meetings, the IRC members use MCIS to identify patterns for individuals and/or providers. If the committee becomes aware of a pattern or suspects a pattern, the IRC Facilitator will enter an incident or issue. If the committee suspects that there is a pattern, the IRC Facilitator or designee will research the concern and report it to the Director of the Quality Assurance and Performance Management Administration (QAPMA).

Monthly the IRC Core Team meets to review data for the past three (3) months to include frequency and types of medication errors to identify individual and/or provider patterns or trends If the committee becomes aware of a pattern or suspects a pattern, the IRC Facilitator will enter an incident or issue. If the committee suspects there is a pattern, the IRC Facilitator or designee will make a recommendation to the responsible DDS unit to research the concern and report to the Deputy Director of the Quality Assurance and Performance Management Administration (QAPMA).

For each quarter, the Quality Assurance and Performance Management Administration (QAPMA) Director designates a person to prepare a summary report for the committee to review, analyze and make recommendations regarding overall incident management system. The quarterly report is submitted to DHCF.

Significant findings from this report are reviewed by the Quality Improvement Committee (QIC) who is charged with making recommendations for quality improvement to the Director of DDS, the DDS Deputy Director for DDA or the Deputy Director of the Quality Assurance and Performance Management Administration (QAPMA).

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

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.

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

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:
HW.a.i.a PM1. Percentage of people who received a fact sheet on how to report abuse, neglect, mistreatment, and exploitation. Numerator: Number of ISPs with documentation that the person received a fact sheet on how to report abuse, neglect, mistreatment, exploitation/Denominator: Number of individual support plans (ISP) reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ISP

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 = DHCF will review a representative sample of ISP's received from DDS with a confidence level of 90% (10% margin of error.)
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW.a.i.a.PM.2.Percentage of all serious reportable incidents reported according to time frames outlined in DDS's Incident Management policies and procedures. N=Number of serious reportable incidents reported according to policies and procedures D= Number of serious reportable incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCIS/Applicable DDS electronic information system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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:
HW.a.i.b.PM.7.Percentage of allegation of abuse, neglect and serious physical injury incidents receiving follow up by IMEU, according to incident management policies and procedures. N=No. of allegations of abuse or neglect, and serious physical injuries receiving follow up according to policies and procedures/D=No. of allegations of abuse or neglect, and serious physical injuries accepted by DDS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCIS/Applicable DDS electronic information system/Investigation Reports

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 =

		90% confidence interval review of incidents with a margin of error of 10%.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW.a.i.b.PM.9.Percentage of serious reportable incidents (except death) receiving follow up by the service coordinator according to incident management policies and procedures. N= Number of serious reportable incidents (except death) receiving follow up by the service coordinator according to policies and procedures D= Number of serious reportable incidents (except death) accepted by DDS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCIS/applicable DDS electronic information system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = DHCF will conduct a 90% confidence Interval review of incidents with 10% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW.a.i.b.PM.4 Number and percent of death investigations where recommended actions to protect health and welfare were implemented. Number of MRC recommendations implemented timely (numerator)/Number of MRC recommendations due during the quarter (denominator).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Death investigation reports

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW.a.i.b.PM.11.Percent of investigations with indication of people being notified of outcome w/i 5 business days of provider receiving investigation report.N=#of incident investigations of allegations of abuse or neglect with notification to waiver participant or representative of outcome within 5 business days of provider receiving investigation report D=#of DDS incident investigations completed.

Data Source (Select one):
Operating agency performance monitoring
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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW.a.i.b.PM.8.Percentage of DDS incident investigations completed/closed timely, according to incident management policies and procedures. Numerator: number of incident investigations closed timely Denominator: number of incident investigations due to be closed that quarter.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCIS/Applicable DDS electronic information system

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

		DHCF will review representative sample of incident investigations. (90% confidence interval with 10% margin of error)
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
HW.a.i.b.PM.3 Percentage of Fatality Review Committee (FRC) recommendations to DDS implemented within the assigned time frame. Number of FRC recommendations implemented within assigned timeframe (numerator)/ Number of FRC recommendations due that quarter (denominator).

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCIS/Applicable DDS electronic information system/FRC Summaries

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW.a.1.b.PM.2 Percentage of investigation recommendations implemented according to Incident management Policies and Procedures. N= Number of investigation recommendations implemented timely/ D= Number of investigations recommendations made for incidents that occurred during the previous quarter.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCIS/Applicable DDS electronic information system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
HW.a.i.c.PM.2. Medications that are not self-administered by appropriately credentialed staff. Number of providers who meet the PCR indicator for administration by trained staff (numerator)/Number of providers for whom that indicator is applicable (denominator).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Certifications

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 = 90% confidence interval review of provider certifications with a margin of error of 10%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW.a.i.c.PM.1.Percentage of people receiving psychotropic medications who had quarterly medication reviews. Number of people who had a timely medication review (numerator)/Number of people scheduled for psychotropic medication review (denominator).

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(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 = Review number of people wit timely medication review using Confidence interval of 90% and a margin of error of 10%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW.a.i.c.PM.3.Percentage of Behavior Support Plans (BSP) containing restrictive measures reviewed by the DDS's Restrictive Control and Review Committee (RCRC). Number of BSPs with restrictive measures reviewed by RCRC (numerator)/Number of BSPs with restrictive measures (denominator).

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCIS/Applicable DDS electronic information system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
HW.a.i.d.PM.1.Percentage of people who received physical exams in accordance with state waiver policies. Number of people who have had a physical exam in the last 12 months (numerator)/Number of people who receive a Residential Monitoring review during the review period (denominator).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Residential Monitoring Tools

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

Appendix A provides a detailed description of discovery and remediation methods that the District will employ for ensuring compliance with waiver requirements regarding Individual Safeguards.

Overall responsibility for performing monitoring and oversight activities for individual safeguards is a shared responsibility of DHCF's Oversight and Monitoring Division with Long Term Care Administration and the Division of Quality and Health Outcomes. Within the Oversight and Monitoring Division with Long Term Care Administration there are designated staff assigned to monitor and provide oversight. Within the Oversight and Monitoring Division with Long Term Care Administration an assigned staff person will monitor and provide oversight.
Within the Continuing Care for Person with Special Needs Branch an assigned staff person will use the above measures to monitor performance with waiver requirements needed to identify, address and prevent the occurrence of abuse, neglect, and exploitation.
Quarterly, DDS will submit incident management data to DHCF. Upon receipt of the data, DHCF's Oversight and Monitoring Division with Long Term Care Administration will analyze the data for individual and systemic concerns.
In addition to DDS submitting data, DHCF will have ongoing access to the DDS, MCIS system. As needed, and within frequencies identified in each performance measure, DHCF will access MCIS to cross reference data submitted by DDS. Findings to this data will be reported to DDS in a quarterly report. Additionally, identified discrepant information will also be included in DHCF's quarterly submission to DDS. Discussion of the findings and discrepant information will occur during monthly DHCF/DDS quality management committee meetings.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

For individual concerns determined to have an immediate impact on the health and welfare of a waiver individual, DHCF will submit concerns to DDS on a Discovery/Remediation Form. The Discovery/Remediation Form will identify the immediate concern, require DDS written action for how the concern will be remediated, and provide timelines for remediation. Systemic concerns will be followed up and communicated to DDS during regular quality management meetings, in the format of a quarterly written report.

In addition to addressing problems and concerns throughout the discovery/remediation format, problems and concerns will be addressed quarterly at quality management meetings, and during weekly teleconference calls between DDS/DHCF.

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**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 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 (QIS) 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 QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. 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.

DHCF and DDS work collaboratively to examine systems, identify issues, and evaluate factors impacting effectiveness, design corrective actions and measure the success of systems improvement. The quality management system is designed to ensure that essential safeguards are met with respect to the health, safety and quality of life for individuals participating in the waiver program as well as to use data to inform systems improvement efforts. The quality management system continues to evolve and improve.

DDS has adopted the Plan-Do-Check-Act (PDCA) Cycle. It is a four-step model for carrying out change which is repeated again and again for continuous improvement.

PlanDoCheckAct Procedure
1. Plan. Recognize an opportunity and plan a change.
2. Do. Test the change.
3. Check. Review the test, analyze the results and identify what youve learned.
4. Act. Take action based on what you learned in the study step: If the change did not work, go through the cycle again with a different plan. If you were successful, incorporate what you learned from the test into wider changes. Use what you learned to plan new improvements, beginning the cycle again.

DHCF and DDS have systems in place to routinely monitor the Districts adherence to the requirements of the waiver based on the assurances and sub-assurances.
The quality management system approaches quality from three perspectives: the individual, the provider and the system. The focus is on discovery of issues, remediation, and service improvement. Information gathered on an individual and provider level is used to remedy situations on those levels and to inform overall system performance analysis and improvements. Discovery and remediation efforts on the individual and provider level are described in previous appendices of this application.
DDS submits routine reports to DHCF of discovery and remediation to demonstrate systems for identifying any individual performance or system issues and evaluating corrective actions in response. DHCF conducts monitoring activities to verify the effectiveness of systems and to notify DDS of any actual or potential individual or system problems. DDS analyzes DHCFs findings to develop and take corrective actions. DHCF then examines the outcomes of corrective action to measure the effectiveness of DDS corrective action.
Data is prepared and shared with the responsible staff within DDS for analysis and recommendations for corrective action. The responsible unit managers participate in monthly Performance Management Meetings with agency leadership with the purpose of discussing the performance on key metrics within the context of the entire service delivery system. This meeting also serves to bring together key agency members to analyze data and make recommendations for further analysis or action. The Performance Management Meetings focus on the integration of work processes and flow so that corrective action is sustainable and effective.

DDS has a variety of databases that enable it to collect and/or review information on important outcomes related to the six (6) assurances under the waiver. These databases include MCIS (DDS Consumer Information System) and Provider Certification Reviews as well as excel documents for tracking other information, including mortality reviews. DDS also has secure access to the Chesapeake Regional Information System for our Patients (CRISP) which serves as the designated Health Information Exchange (HIE) in Maryland and the District of Columbia.

Management reports and the frequency of reports generated from these databases were previously described in the quality improvement sections of Appendices B, C, D, and G. In addition to reports previously mentioned, there are a number of additional ways in which data is aggregated, reported, and reviewed that specifically facilitate the analysis of patterns and trends and the development of service improvement targets. In the District there are four primary external monitoring entities that provide valuable information regarding DDS performance serving individual participants. Quality Trust (QT) and advocacy agency and periodically conducts monitoring activities for people receiving waiver services. The PCR monitors the provider's organizational performance and specific HCBS waiver services. The Columbus Organization investigates the death of people who received services through DDA. Columbus Organization physician reviewers determine whether a death is preventable or not preventable after a careful and thoughtful review of all the records they receive. In addition, Residential Habilitation Services are waiver services provided in licensed homes. These homes are subject to annual licensure reviews by the Department of Health (DC Health) Health Regulatory and Licensing Administration (HRLA). DDS will continue to review the reports from DC Health and the Quality Resource Unit and Health & Wellness team conduct quarterly reviews of deficiencies identified by DC Health via the Statement of Deficiencies reports to verify improvements. The data may be analyzed of the DC Health reports to determine

next steps and if warranted issues are issued and sanctions can be imposed, especially if DC Health identifies an immediate jeopardy for a home.

The Quality Improvement Committee (QIC) is a standing committee established by DDS to review the quality of the Districts service delivery system and to identify broad areas in need of improvement. The QIC also examines integration, coordination, and capacity aspects of the Districts service delivery systems components, including inter-departmental issues. The QIC is designated as the body responsible for systems renewal and continuous quality improvement, with a focus on provider and system issues and trends rather than individual participant issues. The QIC is chaired by the Deputy Director of Quality Assurance and Performance Management Administration (QAPMA) (or designee), and is comprised of the representatives from all divisions, management, and staff. It includes representatives from stakeholder groups including people with disabilities, advocates and family members.

The QIC is responsible for providing the DDS Director and executive management with recommendations concerning goals, objectives and strategies designed to enhance/improve:
1. The service systems responsiveness to individual needs;
2. The service/support performance at provider and systemic levels; and,
3. The integration and coordination of best practices and standards.

Recommendations can be made at any time based on reported findings and analysis.

The DDS Director presents information, reports and analysis for discussion and quality improvement recommendations.
DHCF will use the performance measures specified in Appendices A, B, C, D, & G to assess compliance with each waiver assurance. Overall responsibility for performing monitoring and oversight activities of the identified performance measures is a shared responsibility of the Continuing Care for Persons with Special Needs (Long Term Care Division) Branch and the Division of Quality and Health Outcomes, both within DHCF. Within DHCF's Oversight and Monitoring Division there are designated Management Analyst staff assigned to monitor and provide oversight for each assurance noted in the waiver. These staff persons perform monitoring activities that involve performing desk audits, chart reviews, provider observation and observation of DDAs provider certification review process. Upon discovery of problems or issues, DHCF staff persons report the problems or issues to DDS and require an Opportunity for Improvement Plan (OFIP). DHCF monitors DDS' compliance with an (OFIP) through the ongoing implementation of DHCF's Discovery/Remediation Tools. Meetings are also held on a bi-weekly/monthly basis between DDS and DHCF to discuss operational aspects of the ID/DD waiver implementation to ensure issues requiring remediation are addressed timely and effectively.

In addition to the above, DHCF chairs a quarterly, joint DHCF/DDS Quality Management Committee (QMC) which was re-established in 2011, and includes key leadership from both agencies. The committee meets quarterly and is designed to review performance with the waiver assurances/sub-assurances.
Purposes of the Committee:

1. To review and analyze aggregated data reported;
2. To identify trends reported within the ID/DD service system; and,
3. To make recommendations.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other**	☐ **Other**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
Specify:	Specify:

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.

The Quality Assurance and Performance Management Administration (QAPMA) and senior management staff of the Department on Disability Services have primary responsibility for monitoring the effectiveness of system design changes.

DDS uses a Plan-Do-Check-Act (PDCA) Model for implementing, monitoring, and analyzing the effectiveness of system design changes. Specific staff or units are assigned responsibility for monitoring and analyzing the effectiveness of system design changes. Performance measures are discussed at monthly Performance Management meetings. This is then integrated into the Agency Performance Management Plan for the DDS.

The QAPMA reports quarterly to DHCF regarding DDS discovery and remediation in regards to the waiver assurances and sub-assurances. In addition, the QAPMA has redesigned the incident management reporting system to analyze incidents and make recommendations for provider and systems improvement as the need arises.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

While all individuals within the Department have responsibility for assuring quality, the QAPMA has primary day to day responsibility for assuring that the Department has an effective and efficient quality management system in place for both HCBS waiver and non-waiver services. QAPMA works with internal and external stakeholders and makes recommendations regarding enhancements to the QMS system on an on-going basis.

On an annual basis, considering performance data and input from stakeholders and external monitors, DDAs Leadership evaluates program and operational performance, key performance indicators, and quality management strategies. Results of this review may demonstrate a need to change key performance indicators including changing priorities, using different approaches to ensure progress, modifying roles and responsibilities of key entities, and modifying data sources in order to retrieve the information needed for measurement. These changes are approved by the Office of the City Administrator (OCA) and then integrated into the Annual Performance Management Plan for the DDS.

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).*

Although neither the Medicaid State Agency (DHCF), nor the Operating Agency (DDS) require independent audits of waiver provider agencies, both DHCF and DDS have a number of policies and procedures in place to ensure the integrity of payments made for waiver services. In keeping with CMS instructions, technical guide and review criteria, we describe below DHCF's and DDS' post-payment financial audit activities. Prepayment safeguards are discussed later in this appendix.

Foremost, DHCF's Division of Program Integrity (PI) within the Health Care Operations Administration conducts post-payment audits of HCBS IDD waiver provider claims for Medicaid reimbursement. These annual audits consist of verifying service delivery and billing records to determine if claims for Medicaid reimbursement accurately describe the waiver services delivered, and are in accord with waiver limits and DC regulations governing the HCBS IDD waiver. On a monthly basis, PI conducts ongoing audits of DD waiver providers using a statistically significant sample of paid claims. Providers to be audited will be selected based on the amount of paid claims, the number of enrolled providers, and the last time that the provider type or provider was audited for a specific service. In addition to the monthly audits, PI will continue to address fraud and abuse concerns that are brought to the Division's attention on an ad hoc basis.

In addition, as requested by DDS or DHCF, the DC Office of the Inspector General conducts audits if financial practices are questioned. DDS may also request that a provider have an independent audit completed of its program based on concerns identified through the service authorization review process.

Further, all DC Medicaid services, including services provided through this waiver, are subject to the federally required Single Audit, which is performed by an independent auditor procured and managed by the DC Office of the Inspector General. The Office of Management and Budget has authority over the federally required Single Audit of all federal grant - including Medicaid - recipients. The audit guidance can change from year to year. The most recent guidance publicly available is for FY 2025, and it can be found at https://oig.hhs.gov/compliance/single-audits/frequently-asked-questions-faqs/single-audits-faqs/.

To supplement the audit process, this waiver will require annual cost reports to be submitted by all providers of Residential Habilitation, Supported Living, Supported Living with Transporation, Host Home, Day Habilitation, Individualized Day Supports, In-Home Supports, Employment Readiness, and Supported Employment services. These cost reports will be made available to all auditors as needed.

After the completion of an audit, a Proposed Recoupment Notice is issued to the provider. Once the time for the provider to respond to the proposed notice has expired with no response from the provider or the provider submits records which have been reviewed and any changes to the overpayment has been determined, the Final Recoupment Notice is issued to the provider. After this process is complete, including the resolution of any appeal actions by the provider, the recoupment process is initiated through DHCF's Health Care Operations Administration via memorandum requesting offsets be taken from the provider's future payments. Although, the provider may submit check payment or payments to satisfy the identified overpayment amount. In cases where fraud is suspected, the review specialist or auditor will discuss their concerns with management and a referral will be made to the Investigations Branch for further investigation, if deemed appropriate.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

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.

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

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:
FA.a.1.a.PM.1.Percent of claims for IDD waiver services denied by MMIS, by reason for denial. Numerator: Number of IDD waiver claims denied, by reason of denial. Denominator: Number of claims submitted for reimbursement of IDD Waiver services.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Report from the state fiscal intermediary.

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☑ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
FA.a.1.a.PM.2.Percent of claims reviewed by Program Integrity audits that fail standards. Numerator: Number of audited claims that fail standards Denominator: Number of claims selected for auditing.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☑ ***Less than 100% Review***
☐ ***Sub-State Entity***	☑ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☑ ***Annually***	☐ ***Stratified*** *Describe Group:*

	☐ ***Continuously and Ongoing***	☑ ***Other*** *Specify:* *i. Confidence Level 95 / Desired Precision Range 10* *ii. Confidence Level 90 /DPR 10* *iii. Confidence Level 90 /DPR 15* *iv. Confidence Level 90 / DPR 20*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☑ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

Performance Measure:
FA.a.1.a.PM.4.Number and percent of claims paid with people's person centered plan authorizations (Claims data, plans of care/authorizations). Number of claims paid in accordance with people's persons centered plan authorizations/Number of claims reviewed during the quarter.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS

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 =* *90% (margin of error 10%)*
☑ ***Other*** *Specify:* *State Fiscal intermediary*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☑ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☑ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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.

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.*

Use of the performance measures above will enable the District of Columbia Medicaid program to identify important issues within the waiver program in a timely manner. For example, tracking and trending quarterly utilization and expenditures cumulatively throughout each waiver year for each waiver service will enable the identification of services that are not being utilized as much as projected estimates of its use. This could, for example, lead to discussions with Service Coordinators to ensure that all individuals and their representatives are being informed of all waiver services or lead to revised service projections. Similarly, services that are being utilized at higher than projected amounts, can point to errors in estimated need or utilization, inadequate controls on service utilization, or other issues. Early detection will allow the District to address these variations in utilization and expenditures with the operating agency, Service Coordinators, and advocates, thereby detecting causes and identifying appropriate remedies.

Monthly and quarterly review of denials of claims for reimbursement will highlight providers, services, or waiver processes in need of attention. If, for example, claims were denied frequently for billing in excess of service limits or for services that do not have prior authorization, this will point to the need for more provider training or defects in the prior authorization process that may need remediation.

Analysis of the types of claims that fail audits conducted by DHCF's Division of Program Integrity will also illuminate provider practices. A high incidence of claims that fail audits will point to the need for remedial education and training or provider sanctions. If there is reason to believe that the claims that failed audits were the result of intentional wrongdoing, this will lead to provider sanctions.
Each of the above types of data to be reviewed will be generated from the DC Medicaid claims payment system. They will be reviewed monthly, and trended throughout each waiver year. Analysis of the data will be both qualitative and quantitative, and logic and knowledge of the waiver program and stakeholders will be combined to identify issues and draw conclusion. The analysis will be conducted by staff in DHCF's Oversight and Monitoring Division with Long Term Care Administration. Findings will be shared with the Operating Agency and conclusions and recommendations for remediation will be developed in collaboration with the Operating Agency.

In addition to these systematic strategies for identifying issues within the waiver program, the State Agency and Operating Agency will also document, track, and address individual complaints from beneficiaries, advocates and providers that are received. The quarterly meeting of the Quality Management Committee with stakeholders and the Operating Agency's monthly meetings with providers will serve as key venues for the identification and discovery of issues with the waiver.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

The state deploys multiple methods for addressing individual problems as they are discovered. However, the state first takes action to prevent the occurrence of financial problems by deploying a series of payment edits in the state's MMIS system. At present, all claims for IDD waiver services must pass a series of edits that allow claims to be paid only: 1) to providers who are enrolled in the waiver program and have a waiver provider number, and 2) for individuals who are enrolled in the waiver and have a waiver program enrollment code. Claims can only be paid by Medicaid if they are for services delivered to a waiver individual by a provider enrolled in the waiver. In addition, a series of service-specific edits are placed in MMIS to prevent payment for services in excess of approved waiver limits. Finally, an edit is in place to prevent payment for waiver services that have not been prior authorized by the Operating Agency. All waiver services must be prior authorized by the operating agency.

However, when problems are detected, the State agency (Administrative agency) and the Operating agency (individually or together) deploy a number of different interventions to address the problems.

The interventions to be used depend upon the identified cause(s) of the problem and must be appropriate to the cause(s). Specifically, the cause(s) of the problem may be due to human error, systems errors, failure of technology, or inadequate infrastructure tools and resources, alone or in combination. Following the tenets of root cause analysis, the cause(s) of the problem will first be ascertained. If, for example, human error is identified to be the cause of a problem, the following related questions need to be answered if the remedy is to prevent a recurrence:
1) Was the human action taken, the one that was intended (or was it an accident)?
2) Was the result of the action, the one intended (malfeasance)?
3) Were policies and procedures in place so that the individual had the guidance needed to perform successfully?
4) Was this an isolated error by the individual or part of a pattern? and
5) Similar questions are generated to get to the root of systemic or infrastructure causes of problems.

Once the cause(s) are ascertained, appropriate actions are identified and implemented. Remedies can then include education and training, development of policies and procedures, redesigning work processes, sanctioning individuals, securing needed resources, or other appropriate remedies.

Oversight and remediation are conducted on an ongoing basis by both the Administrative Agency and the Operating Agency, depending on the locus and cause of the problem. If, for example a problem was caused by an issue with the Medicaid claims processing system, then the Administrative agency will address it. If the problem was due to errors committed by Service Coordinators, then the Operating Agency will address it. Often times, both the Operating and Administrative agencies work together in resolving problems (i.e. provider training in new or correct service documentation and billing).

Problems and remedies are jointly discussed at weekly conference calls between the Operating and Administering agency, as well as at monthly Quality Management Committee meetings. These issues and actions are documented in the meeting

agendas and notes.

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***
☐ ***Operating Agency***	☑ ***Monthly***
☐ ***Sub-State Entity***	☑ ***Quarterly***
☐ ***Other*** *Specify:*	☑ ***Annually***
	☑ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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.

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).*

DC requests authority to inflate clinical and wellness services when there is any increase to the DC Living Wage (LW). Residential Habilitation and Supported Living (SL) services rates were established using cost reporting and feedback from the DC provider community regarding ICF/IID rates. DC requested the authority to match the Admin. Rate (13%), Support Service Wages (House Manager, QIDP, DSP RN, LPN) and Paid Time Off factors as approved in the State Plan. The Residential Habilitation and Supported Living services exclude capital, room, board, medical and clinical services. The daily rate includes: DSP LW rate plus overtime and time off; LPN staffing plus overtime and time off to address DC Medication Administration rules; RN oversight for medication administration and health assessments is at 1:12 waiver individuals per DC policy; House Manager for DSP supervision is at 1:12; QIDP for programming responsibilities is at 1:12; 20.75% fringe benefit rate which reflects actual costs; a general and administrative rate of 13% is applied to the total costs of all services based on reasonable comparison of other comparable residential care provider categories. A 95% occupancy rate is applied to the rate to account for hospitalization, Long Term Care, and vacation time that is not billable to the waiver. The Residential Habilitation and Daily Supported Living methodology establishes rates based on the intensity of direct support provided for all people living in the setting on a daily basis and shares the costs of direct support services across all people living in the setting. For settings with variations in the acuity level of residents residing in the setting.

All rates are inflated with the same inflationary rate used by the ICF/IID rate methodology. The waiver rates will be adjusted when the ICF rates are rebased.

The daily rate also includes: DSP wage at the LW of $17.50 for 1:4 staff person to waiver participants in Day Habilitation and 1:3 waiver participants in small group plus overtime and time off calculations; RN oversight for medication administration and health assessments per DC policy of 1:25 individuals for Day Hab and 1:15 for small group; Program Manager for DSP supervision at 1:25 for Day Hab and 1:15 for small group; QIDP for programming responsibilities at 1:25 for Day Hab and 1:15 in small group; 20.75% fringe benefit rate is applied to reflect actual costs in DC; an indirect 25% for transportation, program supplies and quality assurance responsibilities required by DC policy; a general and administrative 13% is applied based on the total costs of all services, based on reasonable comparison with other provider categories; and an 85% occupancy rate applied to the rate to account for hospitalization, Long Term Care and vacation time that is not billable to the waiver program in Day Hab. An occupancy rate of 80% is applied for small group, based on expectations that the acuity of the waiver participants in that program will reflect a higher absence rate. The rates will be inflated by the rate of increase to the DC Living Wage.

Hourly rates like the Day Hab rate shall be reimbursed at $7.10 per 1/4 hour, for a maximum of 6 hrs of service per day or $170.40 per day. Day Hab Small Group shall be reimbursed at $10.27 per 1/4 hour. The rates have remained sufficient to maintain an adequate provider network.

In-home Support (IHS); SLT/P); Hourly Respite (HR); Supported Employment; Group Supported Employment; Individualized Day services (IDS): For these hourly based rates, the following methodology has been used to update the rates following CMS guidance & methodologies employed by other states for fee-for-service rates. Rates include DSP wages, productivity factors, employment related taxes, benefits, indirect or program related support, & administrative overhead expenses. Indirect expenses are calculated based on each service definition & DDA quality requirements. Each hourly rate follows the same methodology with variances in the base wage based on the qualification requirements of the DSP, aligned with the 2024 BLS data for Washington DC metropolitan area if appropriate, productivity assumptions and indirect requirements of the service. As an example, In-home Support reimbursement methodology is calculated using the living wage of $17.50, which is effective January 2025 as the base, a productivity factor of 1.10 for a billable hour of $19.25, an addition of 20.75% for employee related taxes & benefits for a total staff cost of $22.88. An addition of 17% for program support & 13% for administrative overhead is added to the staff cost for a total of $29.75/hour. The DSP rate will be inflated by the rate of increase to the DC LW Rate.

Clinical Services/ Physical Therapy, Speech Therapy and Occupational Therapy:
The waiver program has adopted rates for these clinical services similar to those in use for the DC EPSDT program, which uses the same qualifications for professional personnel to deliver these services and the same method of service delivery. The rates were aligned to expand the number of qualified providers and increase access to this service under the waiver amendment #DC.0307.R03.02 at $100.00/hour for all services in this category and has since been inflated per the approved cost of living adjustments to $120.92 in FY25. Future inflation increases are tied to the rate of increase to the DC Living Wage rate. Family Training is currently $73.52 hourly and will be inflated in the future by the rate of increase to the Living Wage and is compared to State Plan clinical therapies and counseling services.
The Family Training Professional and Parenting Support Professional services are delivered by similarly trained staff

(e.g. teachers, counselors, therapists). As such, the Parenting Support Professional rate has been set at the same amount as the rate for Family Training.
Behavior Support services rates will be inflated in the future by the rate of increase to the Living Wage. The rates have been reviewed relative to the DC State Plan, DC Behavioral Health system, DC Early Intervention Program and MD DD waiver program and remain appropriate. Access to services is also sufficient. Wellness Services were reviewed and adjusted and compared to a variety of competitive DC sources to ensure geographic market equity.
Host Home services rates are based on the waiver participant's level of need as determined by the DC LON and Risk Assessment Tool. The Host Home rates have been inflated for associated cost of living increases aligned with the DC Living Wage rate and review of the methodology indicates that all assumptions remain the same for the amendment. The rates include Host Home recruitment, direct support and supervision costs, employee benefits, respite and program administrative overhead consistent with factors used throughout the DDA HCBS program. The Daily Respite rate has been inflated by the rate of increase to the DC Living Wage and a review of the methodology indicates that all assumptions remain the same. In the future, the rate will be inflated by the rate of increase to the DC Living Wage and in 2025, the rate is increased to $510.74.

Health Assessment and Coordination-Telehealth service will provide specific medical advice where waiver participants would seek additional medical treatment via virtual applications and allow the provision of urgent care telehealth services. The Health Assessment and Coordination (HAC) service is intended for individuals undergoing urgent or emergency clinical events. This service is a monthly subscription service. No more than one (1) unit per month per waiver recipient. The unit rate is $1 per day ($30 per beneficiary per one month unit). The monthly unit covers unlimited access and unlimited calls to specialized physicians, physician assistants, and nurse practitioners for assessment and appropriate intervention.

The Companion 1:2 ratio is for persons residing in Supported Living and Residential Habilitation residential settings who require the appropriate staffing ratio to meet their needs during the day. The proposed rate will be $5.92.

Assistive Technology is capped at $10,000 for the 5-year waiver period based upon a review of other state waivers offering this service. Costs for Assistive Technology purchases and maintenance will be comparable to costs in the DC Vocational Rehabilitation program. The One Time Transitional Services rate is set at $5,000 to match Community Transition, the DC EPD waiver equivalent service and the rate through the Money Follows the Person Demonstration project. Skilled Nursing and Personal Care (PCA) are extended State Plan, matching the State Plan rates. The meals rate was based upon the actual cost of services from local vendors and is inflated using the Living Wage to $9.00 per meal for FY25.

Dental rates are established by DHCF based on an average of all procedure codes; it is an enhancement to the State Plan rate developed through a collaborative process involving DHCF, DDS, providers and stakeholders with any inflation guided by the State Plan.

DSP Wage Enhancement supplemental payments were disbursed to provider agencies in semi-annual, lump-sum allotments. Fringe benefits and administrative expenses associated with the supplemental payment were also included in the supplemental payment. To qualify for a supplemental payment, a provider agency must have submitted cost and employment data (a schedule of DSPs, their wages paid, hours worked, hire dates, and vacancy rates), at the request of the District, and must have demonstrated that supplemental allotments were used to pay DSP staff a benchmark wage rate, set on average 117.6% above DC's minimum/living wage rate. 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 were used for the non-federal share of supplemental payments. Eligible provider agencies retain 100% of the total computable expenditure claimed by the District to CMS. The District may recoup supplemental payments from provider agencies that fail to submit the required cost and employment data or fail to pay DSP staff the benchmark wage rate.

Provider payment rates are uniform for every provider. DHCF & DDS elicit public comments through DC rulemaking process. Information about payment rates is available to participants via publication of proposed & ratified rules. DDS is responsible for the rate development w/ oversight by DHCF. Rate information including public comment is available upon request on DHCF website at http://dhcf.dc.gov & DDS website at http://dds.dc.gov. Information about payment

rates is available to participants via publication of proposed and ratified rules and from their service coordinators.

Direct Support Professionals (DSPs) support will be provided at a proposed ratio of 1:1 while in an acute hospital setting. The SL Periodic rate will be utilized for DSPs providing HCBS for up to 16 hours a day. The rate is $7.70 per 15 minutes. Direct Support Professionals (DSPs) would be providing HCBS in acute care hospital settings to assist persons with one or more of the following: communication; intensive personal care; or behavioral support/stabilization as enumerated in the behavior support plan, on a case-by-case basis. Rates for Direct Support Professionals, whether providing In-Home Supports or Supported Living services, remains the same.

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 provider billings flow directly from providers to the State's claims payment system, the District Medicaid Management Information System (MMIS). MMIS is operated by a CMS-approved external Fiscal Intermediary (FI). This FI is responsible for the operation of the MMIS system and the claims payment system that uses HIPAA compliant codes. The company currently providing these FI services is Conduent. Conduent has a District-based office designed to allow staff to work directly with DHCF to address any concerns on a daily basis regarding claims and claims details. The direct provider of waiver services submits billing electronically or on paper for processing in the MMIS claims payments system. A claims payment cycle is run every week. Payment is slightly longer for paper check claims and mailings and is on a case-by-case basis for special claims. Conduent normally processes all claims associated with the DDS waiver every week. Conduent also employs a Community Representative to work with DHCF and DDS to address DDS waiver provider and billing issues and offer training to address payment questions and provide detailed information.

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.)

☐ ***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.)

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:*

Validation of provider billing occurs in several ways. With respect to assuring that all claims for payments are made only when the individual is eligible for Medicaid waiver payment on the date of service, all claims for DD waiver services must pass a series of payment edits. These edits allow claims to be paid only: 1) to providers who are enrolled in the waiver program and have a waiver provider number, and 2) for individuals who are enrolled in the waiver and have a waiver program enrollment code on the date of service. Claims can only be paid by Medicaid if they are for services delivered to a waiver individual by a provider enrolled in the waiver on the date of service. In addition, a series of service-specific edits are placed in MMIS to prevent payment for services in excess of approved waiver limits.

With respect to ensuring that the service being billed is actually included in the individuals approved service plan, the DC Medicaid waiver program has established procedures to ensure this. First, an edit is in place in the Medicaid Management Information System (MMIS) used to pay all waiver claims to prevent payment for waiver services that have not been prior authorized by the operating agency. All waiver services must be prior authorized by the operating agency. Prior authorization is given by the operating agency only for services that the operating agency authorizes for inclusion in the individuals approved service plan. When the operating agency gives authorization for a service to be included in the service plan, the operating agency transmits a list of authorized services for each individual to a contractor at DHCF, who enters a prior authorization number for each individuals service into the MMIS. The prior authorization number is also given to the contractor. This service and date-specific prior authorization number must accompany each waiver providers claim for Medicaid reimbursement. Reimbursement will not be made unless there is a prior authorization number attached to the claim that matches the beneficiary, service, and date entered by DHCFs contractor into MMIS.

Verification that the services billed for are actually provided is undertaken retrospectively. DHCFs Division of Program Integrity (PI) within the Health Care Operations Administration conducts post-payment audits of HCBS IDD waiver provider claims for Medicaid reimbursement. These annual audits consist of verifying service delivery and billing records to determine if claims for Medicaid reimbursement accurately describe the waiver services delivered, and are in accord with waiver limits and DC regulations governing the HCBS IDD waiver. PI will, on a monthly basis, conduct ongoing audits of DD waiver providers using a statistically significant sample of paid claims. Providers to be audited will be selected based on a consideration of the amount of paid claims, the number of enrolled providers, and the last time that the provider type or provider was audited for a specific service, among other factors. In addition to the monthly audits, the Division of Program Integrity will, on an ad hoc basis, continue to address fraud and abuse concerns that are brought to the Divisions attention on a case by case basis.

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 the 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 living/minimum wage for delivering the following waiver services:

Companion
Day Habilitation
Employment Readiness
Individualized Day Supports
In-Home Supports
Residential Habilitation
Respite
Supported Living Daily and Periodic (with or without transportation)

Supplemental payments will be disbursed to provider agencies in annual, lump-sum allotments. Fringe benefits and administrative expenses associated with the supplemental payment are also included in the supplemental payment.

(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 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 claimed by the District to CMS. The District may recoup supplemental payments from provider agencies that fail to submit the required cost and employment data or pay direct support professional staff 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:

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:

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.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

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 section 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 section 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.

- ***This waiver is a part of a concurrent section 1915(b)/section 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 section 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 section 1115/section 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 section 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 text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 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 section 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 HCBS Waiver rate methodology for residential services explicitly excludes payments for Room and Board, with the singular exception of Daily Respite. DDS collects the waiver individuals SSI/SSDI benefit for those who receive Residential Habilitation and/or Supported Living and in turn provides a $100.00 per month of personal needs allowance and all room and board expenses incurred on behalf of the waiver individual for these specific services. For Host Home services, the HCBS waiver individual's maximum SSI payment is made available to the Host Home provider which is less than the personal needs allowance of $100.00 per month, to account for the HCBS waiver individual's room and board costs. DDS only collects the SSI/SSDI benefit if DDS is the representative payee. If DDS is not the person's representative payee, then the representative payee must disperse the funds to the provider.

For Daily Respite, the waiver payment includes as allowable, a payment for daily room and board equivalent to $20.00 a day.

The contribution to cost of residential supports is a requirement, under D.C. law, that all persons receiving residential services and supports are required to contribute to the cost of those supports and for items such as rent, food, clothing, medical expenses, furniture, utilities, and other personal items and equipment. The law covers people living in host homes, residential habilitation, and supported living settings. Most people contribute to costs from their public benefits, such as Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). People who are employed and still receive public benefits contribute to the cost of residential services and supports based on their combined income.

The Department on Disability Services (DDS), Developmental Disabilities Administration (DDA) released the Contribution to Costs of DDA Residential Supports Policy, 2021-DDA-POL01, and Procedure, 2021-DDA-PR01, effective October 1, 2021. The policy and procedure apply to DDA Residential Providers and people who receive DDA residential supports, including Host Home, Residential Habilitation or Supported Living to implement collaboration in ensuring the contribution to cost of residential supports are paid. The contribution to cost of residential supports is not related to Medicaid benefits paid, but only to Residential Supports which DDA pays with local dollars. Many people with Social Security income (SSI) contribute monthly to the costs of their residential supports and DDS effort is to have most, if not all, persons receiving residential supports comply. This policy and procedure apply the same requirement to people receiving residential supports regardless of the source(s) of their income, as required by District of Columbia law and regulations (D.C. Code §7-761.05). On November 30, 2018, DDS issued a new Chapter 131 in the D.C. Municipal Regulations, entitled, "Contribution to Costs of DDA Residential Supports." Collectively, this policy and procedure specify how DDA will determine whether, what amount and how a person who receives DDA residential supports is required to make required contributions to the costs of residential supports. Persons receiving DDA residential supports are required to contribute up to the current Supplemental Security Income (SSI) maximum or to contribute the difference between the amount their public benefits were reduced due to their employment income. DDS lowers the required contribution as a person approaches retirement age or retires.

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: ICF/IID

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	132725.26	34197.55	166922.81	417070.95	7906.92	424977.87	258055.06
2	168886.54	40482.81	209369.35	415502.85	9553.21	425056.06	215686.71
3	187360.20	47460.90	234821.10	412235.22	11797.41	424032.63	189211.53
4	192735.47	55168.04	247903.51	407157.28	14664.72	421822.00	173918.49
5	201933.71	63616.15	265549.86	400305.45	18176.76	418482.21	152932.35

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:
		ICF/IID
Year 1	*1943*	*1943*
Year 2	*1963*	*1963*
Year 3	*1983*	*1983*
Year 4	*2003*	*2003*
Year 5	*2023*	*2023*

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 of 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 365 days per year.

DC has updated the forecast for the Average Length of Stay. The revised forecast for the average length of stay was determined by taking the total unduplicated participants divided by the total days of the waiver coverage for each waiver year. Historical 372 data was trended from the previous waiver year 4 to the current waiver year 16 to project the average length of stay for the remaining waiver years.

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:*

The estimate of each Factor D component, and how they are combined to calculate Factor D are described below.

Users
In general, the District estimated the number of Users for each service for each year of the waiver renewal by trending historic utilization forward to the waiver period. This historic data used were CMS-372 reports, and - for waiver years more recent than the most recently submitted CMS-372 report - the District compiled the data needed for a CMS-372 report with the understanding that the data may not be complete, but it would still be a useful approximation of the CMS-372 report that would ultimately be submitted. We applied logical limits to the trends - for example: no more users of the service than participants in the waiver, no more users of a service requiring an initial assessment than the sum of initial assessments, etc.

For new services and those that historically have not had any users, we worked with staff from the waiver implementing agency, the Department on Disability Services, to develop a reasonable estimate. For some new services, this was based on expected shifts from current services to new services based on perceived customer interest. For other services, we mirrored the growth in a new service to the growth rates projected for similar established services. For still others, we used averages of User data from older years when there was no recent utilization. There were service changes to include new services and updating scope of specific services. Added Creative Arts Therapies services and rates to the IDD Waiver and added billing rates for waiver services (i.e., Supported Living, In-Home Supports, and Companion), that will be provided during a hospitalization, if there is a difference from the typical billing rate.
Add billing rates for new waiver service (i.e., Health Assessment and Coordination, Assistive Technology ongoing - Extension). Rates have increased since previous submission. Forecast estimates were based on updated actual utilization and then we trended growth based on historical. In some instances, the projected enrollment growth percentage was applied. We also applied the CPI growth rate percentage for average cost per unit. For data sources, we retrieved updated CMS-372 data from the Medicaid Data Warehouse. CPI rates were estimated by the D.C. Office of Revenue Analysis based on forecasts of the D.C. and national economies. Forecast estimates were based on updated actual utilization and then we trended growth based on historical. In some instances, the projected enrollment growth percentage was applied. We also applied the CPI growth rate percentage for average cost per unit.

Average Units per User
In general, the District estimated the Average Units per User for each service for each year of the waiver renewal by trending historic utilization forward to the waiver period. This historic data used were CMS-372 reports, and - for waiver years more recent than the most recently submitted CMS-372 report - the District compiled the data needed for a CMS-372 report with the understanding that the data may not be complete, but it would still be a useful approximation of the CMS-372 report that would ultimately be submitted. We applied logical limits to the trends - for example: services provided on a per-day basis could not have average utilization greater than 365, services with service limitations were limited by the maximum allowable, etc.

For new services and those that historically have not had any utilization, we worked with staff from the waiver implementing agency, the Department on Disability Services, to develop a reasonable estimate. For some new services, this was based on the utilization of current services seen as close substitutes for a new service. For others, we used older utilization data when there was no recent utilization.

Average Cost per Unit
For the first year of the waiver renewal, the average cost per user is simply the rate from Appendix I. The rate methodologies in Appendix I describe how the rates are derived for each service for the first year of the waiver renewal. In many cases, that is simply an inflationary increase to the current rate. For the second year of the renewal through the end of the renewal, the rates are inflated based on our estimate of the consumer price index. That estimate is 2.1% for WY1 and 2.2% for WY2-5 and comes from the District of Columbia Government's Office of Revenue Analysis.

Grand Total Cost
For each service for each year of the renewal, we multiply the Users (described above) by the Average Units per User (described above) which results in our estimate of the Units for that service for that year. We then multiply the Units by the Average Cost per Unit (described above) to get the total cost for each service for each year of the

renewal. For each year of the renewal, we add the total cost for all of the services to get the Grand Total Cost of the waiver for that year.

Factor D
For each year of the renewal, Factor D is derived by dividing the Grand Total Cost (described above) by the Total Unduplicated Participants for that year from Appendix J-2-a. The change in Factor D from one year of the waiver to the next is the net effect of the growth in the number of users of each service, changes in the Average Units per User of each service, the 2.1% for WY1 and 2.2% for WY2-5 estimate of inflation applied to the Average Cost per Unit, and the growth in unduplicated participants. The 2.1% for WY1 and 2.2% for WY2-5 cost per unit inflation is an average across service types based on the base CPI in the CAFR, reflecting the Washington Area CPI change from the prior year.

For WYs 4 and 5 we modified the Users estimate across services to reflect quarterly average and the Average Units per Users to reflect the quarterly sum. The previous submission included quarterly sum for Users and quarterly average for Average Units per Users. The logic behind the change is that the number of users for each quarter consist of the same individuals. The Medicaid Data Warehouse (MDW) 372 reports were run in June 2025 (Q3). That would have been in the period (FY25 - 9/1/24-10/31/25). Since Q3 FY25 had not been completed, we used actuals through Q2 FY25.

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:*

Factor D' estimate includes historical trending historical users and average units/user based on utilization, in addition to taking the historical average cost/claim expenditures and applying the Washington area CPI % WY1 2.1%, and WY2-WY5 2.2% for forecasted WY1-WY5 for each service.

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 growth rate estimate includes trending historical users and avg units/user based on utilization, in addition to taking the historical avg cost/claim expenditures for each service and applying the CPI %, WY1 2.1%, and WY2-WY5 2.2% for forecasted WY1-WY5 for each service.

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' estimates include trending historical and average units/user based on utilization, in addition to taking the historical cost/claim expenditures and applying the CPI %, WY1 2.1%, and WY2-WY5 2.2% for forecasted WY1-WY5 for each service.

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	
Day Habilitation	
Employment Readiness	
In-Home Supports	
Residential Habilitation	
Respite	
Supported Employment	
Personal Care Services	

Waiver Services	
Skilled Nursing	
Assistive Technology Services	
Behavioral Supports	
Companion Services	
Creative Arts Therapies	
Dental	
Family Training	
Health Assessment and Coordination	
Host Home	
Individualized Day Supports	
Occupational Therapy	
One-Time Transitional Services	
Parenting Supports	
Personal Emergency Response System (PERS)	
Physical Therapy	
Small Group Supported Employment	
Speech, Hearing and Language Services	
Supported Living with Transportation	
Supported Living	
Wellness Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**15655414.31**
Day Habilitation (remote)	15 minutes	215	129.59	3.44	**95844.76**	
Day Habilitation 1:6 (remote)	15 minutes	68	94.18	4.20	**26897.81**	
Day Habilitation 1:1	15 minutes	609	941.84	12.10	**6940324.78**	
Day Habilitation	15 minutes	1220	863.94	6.66	**7019685.29**	
Day Habilitation Small Group	15 minutes	167	907.30	9.64	**1460644.12**	

GRAND TOTAL: 257885173.02

Total Estimated Unduplicated Participants: 1943

Factor D (Divide total by number of participants): 132725.26

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation w/ meals (1:1)	1 day	4	61.90	5.80	1436.08	
Small Group Day Hab 1:6 (Remote)	15 minutes	20	90.73	4.89	8873.39	
Day Hab w/ Meals delivered by Third Party Vendor	1 day	328	36.74	8.44	101708.08	
Employment Readiness Total:						4934566.18
Employment Readiness (Remote)	15 minutes	268	155.92	2.97	124106.08	
Pre-Vocational/Employment Readiness	15 minutes	1075	779.59	5.74	4810460.10	
In-Home Supports Total:						30584588.56
High Intensive In-Home Supports	15 minutes	140	2608.85	7.62	2783121.18	
In-Home Supports	15 minutes	1943	2372.89	6.03	27801467.38	
In-Home Supports (Remote)	15 minutes	0	0.00	1.00	0.00	
In-Home Supports (Acute Care Hospital Setting)	15 minutes	0	0.00	1.00	0.00	
Residential Habilitation Total:						22417555.17
Res Hab 4 Intensive w/ 24 hr LPN (U1 TE)	1 day	32	365.00	626.57	7318337.60	
Res Hab 5-6 Intensive w/ 24 hr LPN (U2-HI)	1 day	10	306.74	524.11	1607655.01	
Resident Habilitation 4 Res - Basic (U1)	1 day	14	110.84	275.70	427820.23	
Resident Habilitation 4 Res - Enhanced (U3)	1 day	44	257.25	434.06	4913125.14	
Resident Habilitation 4 Res - Intensive (U4)	1 day	12	226.92	527.89	1437465.59	
Resident Habilitation 4 Res - Moderate (U2)	1 day	10	231.00	387.40	894894.00	
Resident Habilitation 5-6 Res - Basic (U5)	1 day	19	170.17	298.80	966089.12	
Res Hab 5-6 Res (Enhanced - U7)	1 day	24	204.17	411.21	2014961.90	
Resident Habilitation 5-6 Res - Intensive (U8)	1 day	12	214.25	512.55	1317766.05	
Res Hab 5-6 Res (Moderate- U6)	1 day	21	195.96	369.23	1519440.53	
Respite Total:						3040223.85

GRAND TOTAL: 257885173.02

Total Estimated Unduplicated Participants: 1943

Factor D (Divide total by number of participants): 132725.26

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite - Hourly	15 minutes	483	511.87	6.61	1634211.52	
Respite - Daily	1 day	106	26.77	495.49	1406012.33	
Supported Employment Total:						1860521.09
Individual Supported Employment - Intake and Assessment Paraprofessional (Remote)	15 minutes	8	47.30	7.81	2955.30	
Individual Supported Employment - Intake and Assessment Professional (Remote)	15 minutes	4	27.00	14.09	1521.72	
Individual Supported Employment - Job Placement Paraprofessional (Remote)	15 minutes	8	47.30	7.81	2955.30	
Individual Supported Employment - Job Placement Professional (Remote)	15 minutes	5	12.00	14.09	845.40	
Individual Supported Employment - Training & Supports Paraprofessional (Remote)	15 minutes	12	26.21	7.81	2456.40	
Individual Supported Employment - Training & Supports Professional (Remote)	15 minutes	8	53.47	3.77	1612.66	
Individual Supported Employment - Long Term Follow Along Paraprofessional (Remote)	15 minutes	4	9.29	7.81	290.22	
Long-Term Supported Employment - Follow Along	15 minutes	36	183.40	14.09	93027.82	
Long-Term Follow Along Paraprofessional	15 minutes	31	185.82	7.81	44988.88	
Supported Employment - Training & Supports Paraprofessional w/ EXT	15 minutes	0	0.00	0.01	0.00	
Supported Employment - Training & Supports Professional w/ EXT	15 minutes	0	0.00	0.01	0.00	
Training & Supports Professional w/ EXT (Remote)	15 minutes	0	0.00	0.01	0.00	
SE- Assessment Paraprofessional	assessment	1	1.00	7.81	7.81	
SE- Assessment Professional	assessment	4	108.00	14.09	6086.88	

GRAND TOTAL: 257885173.02

Total Estimated Unduplicated Participants: 1943

Factor D (Divide total by number of participants): 132725.26

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
SE- Placement Paraprofessional	15 minutes	38	236.48	7.81	70182.53	
SE- Placement Professional	15 minutes	103	240.00	14.09	348304.80	
SE- Training Paraprofessional	15 minutes	61	524.18	7.81	249724.59	
SE- Training Professional	15 minutes	129	569.58	14.09	1035274.30	
Long Term Follow Along Professional (Remote)	15 minutes	4	9.17	7.81	286.47	
Personal Care Services Total:						0.00
Personal Care	15 minutes	0	0.00	5.98	0.00	
Skilled Nursing Total:						1194719.71
Skilled Nursing - Visit/RN	15 minutes	0	0.00	16.81	0.00	
Skilled Nursing - Extended/RN	15 minutes	4	1284.43	16.81	86365.07	
Skilled Nursing - Initial Assessment	flat rate	0	0.00	134.46	0.00	
Skilled Nursing - Extended/LPN/LVN	15 minutes	32	2472.24	14.01	1108354.64	
Assistive Technology Services Total:						229484.00
Assistive Technology-Goods	item	40	1.00	5000.00	200000.00	
Assistive Technology (Remote)	15 minutes	0	0.00	1.00	0.00	
Assistive Technology-Services	15 minutes	130	8.00	28.35	29484.00	
Assistive Technology - Ongoing	15 minutes	0	0.00	1.00	0.00	
Assistive Technology-Ongoing (Remote)	15 minutes	0	0.00	1.00	0.00	
Assistive Technology-PERS (Installation)	item	0	0.00	57.31	0.00	
Assistive Technology-PERS (Monthly)	1 month	0	0.00	35.22	0.00	
Behavioral Supports Total:						10899248.33
Behavior Support - Diagnostic Assessment	flat rate	43	1.00	285.16	12261.88	
Behavior Support - Non-professional Services	15 minutes	358	3551.16	6.76	8594091.29	

GRAND TOTAL: 257885173.02

Total Estimated Unduplicated Participants: 1943

Factor D (Divide total by number of participants): 132725.26

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavior Support - Paraprofessional Services	15 minutes	256	37.40	18.81	180094.46	
Behavior Support - Professional Services	15 minutes	1150	34.70	30.56	1219496.80	
Behavior Support - Diagnostic Assessment (Remote)	flat rate	29	0.40	285.16	3307.86	
Behavior Support - Non-professional Services (Remote)	15 minutes	95	761.49	7.15	517242.08	
Behavior Support - Paraprofessional Services (Remote)	15 minutes	170	14.96	18.81	47837.59	
Behavior Support - Professional (Remote)	15 minutes	766	13.88	30.56	324916.36	
Companion Services Total:						22204368.58
Companion Services Individual	15 minutes	1729	1609.79	6.14	17089627.23	
Companion Services Group	15 minutes	1436	1203.31	2.96	5114741.35	
Companion 1:2	15 minutes	0	0.00	1.00	0.00	
Creative Arts Therapies Total:						109790.48
Creative Arts Therapies (CAT) - Dance	45 minutes	0	0.00	28.35	0.00	
CAT -Art (Remote)	45 minutes	26	6.90	28.35	5085.99	
CAT - Art	45 minutes	40	17.25	28.35	19561.50	
CAT - Art Therapy Group	45 minutes	0	0.00	28.35	0.00	
CAT - Drama	45 minutes	0	0.00	28.35	0.00	
CAT - Music Therapy Group, up to 4 PPL	45 minutes	0	0.00	28.35	0.00	
CAT- Music Therapy w/ EXT	45 minutes	0	0.00	1.00	0.00	
CAT- Music Therapy w/ EXT (Remote)	45 minutes	0	0.00	1.00	0.00	
CAT - Dance Therapy w/ EXT	45 minutes	0	0.00	1.00	0.00	
CAT - Dance Therapy w/ EXT- Remote	45 minutes	0	0.00	1.00	0.00	
CAT - Drama Therapy w/ EXT	45 minutes	0	0.00	1.00	0.00	

GRAND TOTAL: 257885173.02

Total Estimated Unduplicated Participants: 1943

Factor D (Divide total by number of participants): 132725.26

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CAT - Drama Therapy w/ EXT- Remote	45 minutes	0	0.00	1.00	0.00	
CAT - Dance Therapy Group w/ EXT	45 minutes	0	0.00	1.00	0.00	
CAT - Dance Therapy Group w/ EXT- Remote	45 minutes	0	0.00	1.00	0.00	
CAT - Drama Therapy Group w/ EXT	45 minutes	0	0.00	1.00	0.00	
CAT - Drama Therapy Group w/ EXT- Remote	45 minutes	0	0.00	1.00	0.00	
CAT- Art Therapy w/EXT	45 minutes	0	0.00	1.00	0.00	
CAT- Art Therapy w/EXT (Remote)	45 minutes	0	0.00	1.00	0.00	
CAT- Art Therapy Group EXT	45 minutes	0	0.00	1.00	0.00	
CAT- Art Therapy Group EXT (Remote)	45 minutes	0	0.00	1.00	0.00	
CAT- Dance Therapy (Remote)	45 minutes	0	0.00	28.35	0.00	
CAT- Dance Therapy Group	45 minutes	0	0.00	1.00	0.00	
CAT- Drama Therapy Remote	45 minutes	0	0.00	1.00	0.00	
CAT- Drama Therapy Group	45 minutes	0	0.00	1.00	0.00	
CAT- Music Therapy	45 minutes	98	24.14	28.35	67068.16	
CAT- Music Therapy (Remote)	45 minutes	66	9.66	28.35	18074.83	
CAT- Music Therapy Group w/EXT	45 minutes	0	0.00	1.00	0.00	
CAT- Music Therapy Group w/ EXT (Remote)	45 minutes	0	0.00	1.00	0.00	
Dental Total:						0.00
Dental Services	visit	0	0.00	114.34	0.00	
Family Training Total:						16950.54
Family Training - Remote	15 minutes	4	8.30	17.25	572.70	
Family Training - Non-Family	15 minutes	8	20.75	17.25	2863.50	
Family Training - Non-Family (Remote)	15 minutes				572.70	

GRAND TOTAL: 257885173.02

Total Estimated Unduplicated Participants: 1943

Factor D (Divide total by number of participants): 132725.26

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		4	8.30	17.25		
Family Training - Professional	15 minutes	12	62.52	17.25	12941.64	
Family Training - Small Group Peer	15 minutes	0	0.00	9.48	0.00	
Family Training - Small Group Professional	15 minutes	0	0.00	6.96	0.00	
Health Assessment and Coordination Total:						0.00
Health Assessment and Coordination Telehealth Service	monthly	0	0.00	1.00	0.00	
Host Home Total:						9580573.91
Host Home Residential Care - Basic (UA)	1 day	163	85.52	182.07	2538012.10	
Host Home Residential Care - Med (UB)	1 day	72	88.79	203.63	1301782.15	
Host Home Residential Care - High (UC)	1 day	114	90.89	264.71	2742782.08	
Host Home Residential Care - High (UD)	1 day	56	89.39	598.90	2997997.58	
Individualized Day Supports Total:						9663234.11
Individualized Day Support - 1:1	15 minutes	418	760.65	10.03	3189055.55	
Individualized Day Support 1:2	15 minutes	1504	608.00	7.08	6474178.56	
Occupational Therapy Total:						208523.32
Occupational Therapy	15 minutes	320	22.73	28.35	206206.56	
OT- Assessment Ongoing (Remote)	15 minutes	36	2.27	28.35	2316.76	
One-Time Transitional Services Total:						5105.00
One-Time Transitional Services	1 unit	1	1.00	5105.00	5105.00	
Parenting Supports Total:						859607.58
Parenting Support - Peer	15 minutes	12	555.14	9.48	63152.73	
Parenting Support - Professional	15 minutes	72	552.93	17.23	685942.84	
Parenting Support - Small Group Peer	15 minutes	0	0.00	2.79	0.00	
Parenting Support -					0.00	

GRAND TOTAL: 257885173.02

Total Estimated Unduplicated Participants: 1943

Factor D (Divide total by number of participants): 132725.26

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Small Group Professional	15 minutes	0	0.00	2.79		
Parenting Support - Individual Professional (Remote)	15 minutes	29	221.17	17.23	110512.01	
Personal Emergency Response System (PERS) Total:						0.00
PERS- Installation	flat rate	0	0.00	57.31	0.00	
PERS- Monthly Service	monthly	0	0.00	35.22	0.00	
Physical Therapy Total:						616741.78
Physical Therapy	15 minutes	688	31.62	28.35	616741.78	
Small Group Supported Employment Total:						1115918.36
SE Gp Job Training & Supports Professional	15 minutes	129	534.73	14.09	971930.60	
SE Gp Job Training & Supports Professional (Remote)	15 minutes	8	53.47	3.77	1612.66	
SE Gp Job Training & Supports Paraprofessional	15 minutes	61	617.08	3.77	141909.89	
SE Gp Job Training & Supports Paraprofessional (Remote)	15 minutes	4	30.85	3.77	465.22	
Speech, Hearing and Language Services Total:						857104.42
Speech, Hearing and Language - Individual	15 minutes	784	36.63	28.35	814153.03	
Speech, Hearing and Language - Small Group	15 minutes	0	0.00	13.82	0.00	
Speech, Hearing and Language Assessment	15 minutes	68	17.34	28.35	33428.05	
Speech, Hearing and Language Assessment (Remote)	15 minutes	8	1.73	28.35	392.36	
Speech, Hearing and Language Service - Individual (Remote)	15 minutes	88	3.66	28.35	9130.97	
Supported Living with Transportation Total:						66034874.88
SL (1) 1:1 AON w/TRANS (R-ON)	1 day	12	4.25	758.51	38684.01	
SL (1) 1:1 AON w/TRANS (R-ON) +1	1 day	12	4.25	719.99	36719.49	
SL (1) 1:1 AON w/TRANS (R-ON) +2	1 day	12	4.25	618.81	31559.31	

GRAND TOTAL: 257885173.02

Total Estimated Unduplicated Participants: 1943

Factor D (Divide total by number of participants): 132725.26

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
SL(2) Basic Support Level 1 w/TRANS (R-ON)	1 day	0	0.00	323.24	0.00	
SL(2)Basic Support Level 1 w/TRANS (R-ON) +1	1 day	0	0.00	333.91	0.00	
SL(2)Basic Support Level 1 w/TRANS (R-ON) +2	1 day	0	0.00	331.70	0.00	
SL(2) Inten Support Level 1 w/TRANS (R-ON)	1 day	28	3.70	641.83	66493.59	
SL(2) Inten Support Level 1 w/TRANS (R-ON) +1	1 day	28	3.70	632.18	65493.85	
SL(2) Inten Support Level 1 w/TRANS (R-ON) +2	1 day	28	3.70	565.79	58615.84	
SL(2) Mod Support Level 1 w/TRANS (R-ON)	1 day	4	0.40	496.98	795.17	
SL(2) Mod Support Level 1 w/TRANS (R-ON) +1	1 day	4	0.40	495.83	793.33	
SL(2) Mod Support Level 1 w/TRANS (R-ON) +2	1 day	4	0.40	469.97	751.95	
SL(3) Basic Support Level 1 w/TRANS (R-ON)	1 day	0	0.00	323.24	0.00	
SL(3) Basic Support Level 1 w/TRANS (R-ON) +1	1 day	4	14.74	313.09	18459.79	
SL(3) Basic Support Level 1 w/TRANS (R-ON) +2	1 day	4	14.74	288.52	17011.14	
SL(3) Inten Support Level 1 w/TRANS (R-ON)	1 day	12	8.60	471.10	48617.52	
SL(3) Inten Support Level 1 w/TRANS (R-ON) +1	1 day	12	8.60	485.11	50063.35	
SL(3) Inten Support Level 1 w/TRANS (R-ON) +2	1 day	12	8.60	466.02	48093.26	
SL (3) Moderate Support Level 1 W/TRANS (R-ON)	1 day	4	4.28	406.13	6952.95	
SL (3) Moderate Support Level 1 W/TRANS (R-ON) + 1	1 day	4	4.28	404.97	6933.09	
SL (3) Moderate Support Level 1 W/TRANS (R-ON) + 2	1 day	4	4.28	379.12	6490.53	
SL 1 Res (Asleep ON) w/TRANS (UD-HI)	1 day	4	35.00	935.30	130942.00	
SL 1 Res (AON) w/TRANS (UC-HI)	1 day				14555437.90	

GRAND TOTAL: 257885173.02

Total Estimated Unduplicated Participants: 1943

Factor D (Divide total by number of participants): 132725.26

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		183	85.04	935.30		
SL 1 Res (Periodic) w/ TRANS (U1 - HI)	15 minutes	28	312.00	8.22	71809.92	
SL 2 Res (Basic 1) w/ TRANS (U7 - HI)	1 day	4	63.00	496.64	125153.28	
SL 2 Res (Basic 2) w/ TRANS (U8 - HI)	1 day	78	321.54	415.32	10416275.44	
SL 2 Res (Moderate 1) w/ Transportation (U9 - HI)	1 day	4	8.00	575.13	18404.16	
SL 2 Res (Intensive 1) w/ Transportation (UB - HI)	1 day	474	73.96	727.79	25514163.14	
SL 2 Res (Moderate 2) w/ Transportation (UA - HI)	1 day	5	216.08	530.94	573627.58	
SL 3 Intensive w/ LPN w/ Transportation (TE - HI)	1 day	36	82.68	660.81	1966887.75	
SL 3 Res (Basic 1) w/ Transportation (U1- HI)	1 day	0	0.00	323.24	0.00	
SL 3 Res (Basic 2) w/ Transportation (U2 - HI)	1 day	69	87.79	366.24	2218502.46	
SL 3 Res (Intensive 1) w/ Transportation (U5 - HI)	1 day	14	259.74	472.94	1719780.10	
Supported Living 3 Res (Intensive 2) w/ Transportation (U6 - HI)	1 day	40	272.24	523.89	5704952.54	
Supported Living 3 Res (Moderate 2) w/ Transportation (U4 - HI)	1 day	76	48.73	635.64	2354080.03	
Res - Moderate 1 w/ Transportation (U3 HI)	1 day	1	214.59	421.83	90520.50	
SL Periodic with transportation (Remote)	15 minutes	28	312.00	8.22	71809.92	
Supported Living Total:						53010831.19
SL (1) One to One Awake Overnight (R-ON)	1 day	8	4.04	603.24	19496.72	
SL (1) One to One Awake Overnight (R-ON) +1	1 day	8	4.04	564.83	18255.31	
SL (1) One to One Awake Overnight (R-ON) +2	1 day	8	4.04	463.65	14985.17	
SL (2) Basic Support Level 1 (R-ON)	1 day	4	14.74	329.44	19423.78	
SL (2) Basic Support					18459.79	

GRAND TOTAL: 257885173.02

Total Estimated Unduplicated Participants: 1943

Factor D (Divide total by number of participants): 132725.26

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 1 (R-ON) +1	1 day	4	14.74	313.09		
SL (2) Basic Support Level 1 (R-ON) +2	1 day	4	14.74	288.52	17011.14	
SL (2) Inten Support Level 1 (R-ON)	1 day	12	3.78	550.98	24992.45	
SL (2) Inten Support Level 1 (R-ON) +1	1 day	12	3.78	541.33	24554.73	
SL (2) Inten Support Level 1 (R-ON) +2	1 day	12	3.78	474.93	21542.82	
SL (2) Mod Support Level 1 (R-ON)	1 day	4	4.28	406.13	6952.95	
SL (2) Mod Support Level 1 (R-ON) +1	1 day	4	4.28	404.97	6933.09	
SL (2) Mod Support Level 1 (R-ON) +2	1 day	4	3.28	379.12	4974.05	
SL (3) Basic Support Level 1 (R-ON)	1 day	4	7.57	253.82	7685.67	
SL (3) Basic Support Level 1 (R-ON) +1	1 day	4	7.57	264.49	8008.76	
SL (3) Basic Support Level 1 (R-ON) +2	1 day	4	7.57	262.28	7941.84	
SL (3) Intens Support Level 1 (R-ON)	1 day	22	8.49	401.68	75025.79	
SL (3) Intens Support Level 1 (R-ON) + 1	1 day	22	8.49	415.69	77642.58	
SL (3) Intens Support Level 1 (R-ON) + 2	1 day	22	8.49	396.61	74078.82	
SL (3) Moderate Support Level (1) (R-ON)	1 day	4	42.00	366.63	61593.84	
SL (3) Moderate Support Level (1) (R-ON) + 1	1 day	4	42.00	382.63	64281.84	
SL (3) Moderate Support Level (1) (R-ON) + 2	1 day	4	42.00	374.77	62961.36	
SL Periodic	15 minutes	0	0.00	0.01	0.00	
SL 1 Res (Asleep ON-UD)	1 day	4	25.00	773.32	77332.00	
SL 1 Res (Awake ON-UC)	1 day	126	80.78	773.32	7871067.49	
SL 1 Res (Periodic- U1)	15 minutes	97	9995.45	6.26	6069437.15	
SL 2 Res (Basic 1-U7)	1 day	5	73.71	402.18	148223.44	

GRAND TOTAL: 257885173.02

Total Estimated Unduplicated Participants: 1943

Factor D (Divide total by number of participants): 132725.26

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
SL 2 Res Basic 2- U8)	1 day	44	75.17	588.86	1947642.67	
SL 2 Res (Intensive 1- UB)	1 day	80	223.38	532.65	9518668.56	
SL 2 Res (Moderate 1- U9)	1 day	24	85.57	480.67	987142.37	
SL 2 Res (Moderate 2- UA)	1 day	134	86.20	541.18	6251061.94	
SL 3 Intensive w/ LPN (U1-TE)	1 day	10	363.21	520.36	1889999.56	
SL 3 Res (Basic 1- U1)	1 day	4	75.72	294.30	89137.58	
SL 3 Res (Basic 2- U2)	1 day	42	85.44	294.30	1056089.66	
SL 3 Res (Intensive 1- U5)	1 day	153	84.89	448.11	5820128.86	
SL Res (Intensive 2- U6)	1 day	206	86.91	523.47	9371924.21	
SL 3 Res (Moderate 1- U3)	1 day	4	84.00	411.30	138196.80	
SL 3 Res (Moderate 2- U4)	1 day	33	73.91	411.29	1003148.65	
SL Periodic (Remote)	15 minutes	55	583.67	4.20	134827.77	
SL (Acute Care Hospital Setting)	15 minutes	0	0.00	1.00	0.00	
Wellness Services Total:						2785227.67
Wellness Services - Fitness Trainer Individual	15 minutes	1387	52.00	21.26	1533356.24	
Wellness Services - Fitness Trainer Group	15 minutes	13	52.00	12.76	8625.76	
Wellness Services - Bereavement Counseling	15 minutes	18	31.89	18.43	10579.19	
Wellness Services - Healthy Relationships	15 minutes	78	45.71	21.98	78367.05	
Wellness Services - Nutritional Counseling	15 minutes	1932	26.00	18.81	944863.92	
Wellness Services - Fitness Trainer Individual (Remote)	15 minutes	347	10.40	21.26	76723.09	
Wellness Services - Fitness Trainer Group (Remote)	15 minutes	4	10.40	12.76	530.82	
Wellness Services - Bereavement Counseling (Remote)	15 minutes	4	6.38	18.43	470.33	

GRAND TOTAL: 257885173.02

Total Estimated Unduplicated Participants: 1943

Factor D (Divide total by number of participants): 132725.26

Average Length of Stay on the Waiver: 355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Wellness Services - Healthy Relationships (Remote)	15 minutes	20	9.14	21.98	4017.94	
Wellness Services - Nutritional Counseling (Remote)	15 minutes	491	5.20	18.81	48025.69	
Wellness Services- Massage Therapy	15 minutes	87	52.00	17.61	79667.64	

GRAND TOTAL: 257885173.02
Total Estimated Unduplicated Participants: 1943
Factor D (Divide total by number of participants): 132725.26
Average Length of Stay on the Waiver: 355

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						16438026.93
Day Habilitation (remote)	15 minutes	195	130.63	3.52	89664.43	
Day Habilitation 1:6 (remote)	15 minutes	70	94.56	4.29	28396.37	
Day Habilitation 1:1	15 minutes	627	945.59	12.37	7333986.58	
Day Habilitation	15 minutes	1193	870.85	6.81	7075072.78	
Day Habilitation Small Group	15 minutes	182	1014.48	9.86	1820504.65	
Day Habilitation w/ meals (1:1)	1 day	4	66.43	5.93	1575.72	
Small Group Day Hab 1:6 (Remote)	15 minutes	20	101.40	5.00	10140.00	
Day Hab w/ Meals delivered by Third Party Vendor	1 day	65	156.00	7.76	78686.40	
Employment Readiness Total:						6330943.88
Employment Readiness (Remote)					158705.10	

GRAND TOTAL: 331524271.92
Total Estimated Unduplicated Participants: 1963
Factor D (Divide total by number of participants): 168886.54
Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 minutes	268	195.44	3.03		
Pre-Vocational/Employment Readiness	assessment	1076	977.22	5.87	6172238.79	
In-Home Supports Total:						39606816.71
High Intensive In-Home Supports	15 minutes	168	2841.85	7.79	3719185.93	
In-Home Supports	15 minutes	1963	2564.10	7.13	35887630.78	
In-Home Supports (Remote)	15 minutes	0	0.00	1.00	0.00	
In-Home Supports (Acute Care Hospital Setting)	15 minutes	0	0.00	1.00	0.00	
Residential Habilitation Total:						26271281.33
Res Hab 4 Intensive w/ 24 hr LPN (U1 TE)	1 day	37	45.21	707.76	1183919.70	
Res Hab 5-6 Intensive w/ 24 hr LPN (U2-HI)	1 day	44	91.25	596.96	2396794.40	
Resident Habilitation 4 Res - Basic (U1)	1 day	8	89.24	325.45	232345.26	
Resident Habilitation 4 Res - Enhanced (U3)	1 day	122	88.45	511.29	5517279.26	
Resident Habilitation 4 Res - Intensive (U4)	1 day	108	84.13	623.32	5663510.45	
Resident Habilitation 4 Res - Moderate (U2)	1 day	12	88.04	456.28	482050.69	
Resident Habilitation 5-6 Res - Basic (U5)	1 day	4	91.25	349.50	127567.50	
Res Hab 5-6 Res (Enhanced - U7)	1 day	78	91.25	453.90	3230633.25	
Resident Habilitation 5-6 Res - Intensive (U8)	1 day	90	88.72	589.67	4708397.02	
Res Hab 5-6 Res (Moderate- U6)	1 day	72	91.25	415.34	2728783.80	
Respite Total:						3445688.60
Respite - Hourly	15 minutes	494	529.78	6.75	1766551.41	
Respite - Daily	1 day	114	30.08	489.67	1679137.19	
Supported Employment Total:						1891049.05
Individual Supported Employment - Intake and Assessment	15 minutes	1	0.50	7.81	3.90	

GRAND TOTAL: 331524271.92

Total Estimated Unduplicated Participants: 1963

Factor D (Divide total by number of participants): 168886.54

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Paraprofessional (Remote)						
Individual Supported Employment - Intake and Assessment Professional (Remote)	15 minutes	4	27.00	14.40	1555.20	
Individual Supported Employment - Job Placement Paraprofessional (Remote)	15 minutes	8	48.00	7.98	3064.32	
Individual Supported Employment - Job Placement Professional (Remote)	15 minutes	8	12.00	14.40	1382.40	
Individual Supported Employment - Training & Supports Paraprofessional (Remote)	15 minutes	12	27.08	7.98	2593.18	
Individual Supported Employment - Training & Supports Professional (Remote)	15 minutes	28	58.65	14.40	23647.68	
Individual Supported Employment - Long Term Follow Along Paraprofessional (Remote)	15 minutes	4	10.17	7.98	324.63	
Long-Term Supported Employment - Follow Along	15 minutes	43	195.23	14.40	120886.42	
Long-Term Follow Along Paraprofessional	15 minutes	36	541.68	7.98	155613.83	
Supported Employment - Training & Supports Paraprofessional w/ EXT	15 minutes	0	0.00	0.01	0.00	
Supported Employment - Training & Supports Professional w/ EXT	15 minutes	0	0.00	0.01	0.00	
Training & Supports Professional w/ EXT (Remote)	15 minutes	0	0.00	0.01	0.00	
SE- Assessment Paraprofessional	assessment	1	1.00	7.98	7.98	
SE- Assessment Professional	15 minutes	4	108.00	14.40	6220.80	
SE- Placement Paraprofessional	15 minutes	38	240.00	7.98	72777.60	
SE- Placement Professional	15 minutes	133	108.00	14.40	206841.60	
SE- Training Paraprofessional	15 minutes	61	707.02	3.86	166474.93	
SE- Training Professional	15 minutes				1129343.04	

GRAND TOTAL: 331524271.92

Total Estimated Unduplicated Participants: 1963

Factor D (Divide total by number of participants): 168886.54

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		140	560.19	14.40		
Long Term Follow Along Professional (Remote)	15 minutes	4	9.76	7.98	311.54	
Personal Care Services Total:						6.11
Personal Care	15 minutes	1	1.00	6.11	6.11	
Skilled Nursing Total:						1558427.02
Skilled Nursing - Visit/RN	15 minutes	1	1.00	17.18	17.18	
Skilled Nursing - Extended/RN	15 minutes	5	1350.76	17.10	115489.98	
Skilled Nursing - Initial Assessment	flat rate	0	0.00	137.41	0.00	
Skilled Nursing - Extended/LPN/LVN	15 minutes	32	3148.83	14.32	1442919.86	
Assistive Technology Services Total:						136288.00
Assistive Technology-Goods	item	20	1.00	5000.00	100000.00	
Assistive Technology (Remote)	15 minutes	0	0.00	1.00	0.00	
Assistive Technology-Services	15 minutes	160	8.00	28.35	36288.00	
Assistive Technology - Ongoing	15 minutes	0	0.00	1.00	0.00	
Assistive Technology-Ongoing (Remote)	15 minutes	0	0.00	1.00	0.00	
Assistive Technology-PERS (Installation)	item	0	0.00	1.00	0.00	
Assistive Technology-PERS (Monthly)	1 month	0	0.00	1.00	0.00	
Behavioral Supports Total:						12743517.36
Behavior Support - Diagnostic Assessment	flat rate	52	1.00	291.43	15154.36	
Behavior Support - Non-professional Services	15 minutes	378	3807.45	7.15	10290395.12	
Behavior Support - Paraprofessional Services	15 minutes	262	37.41	19.23	188481.31	
Behavior Support - Professional Services	15 minutes	1202	35.06	31.23	1316098.41	
Behavior Support - Diagnostic Assessment (Remote)	flat rate	34	0.40	281.43	3827.45	

GRAND TOTAL: 331524271.92

Total Estimated Unduplicated Participants: 1963

Factor D (Divide total by number of participants): 168886.54

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavior Support - Non-professional Services (Remote)	15 minutes	96	752.13	7.31	527814.75	
Behavior Support - Paraprofessional Services (Remote)	15 minutes	175	14.96	19.23	50344.14	
Behavior Support - Professional (Remote)	15 minutes	802	14.03	31.23	351401.83	
Companion Services Total:						27403746.38
Companion Services Individual	15 minutes	1805	1796.08	6.28	20359285.23	
Companion Services Group	15 minutes	1727	1346.21	3.03	7044461.15	
Companion 1:2	15 minutes	0	0.00	1.00	0.00	
Creative Arts Therapies Total:						135456.48
Creative Arts Therapies (CAT) - Dance	45 minutes	1	1.00	28.97	28.97	
CAT -Art (Remote)	45 minutes	33	7.03	28.97	6720.75	
CAT - Art	45 minutes	118	24.62	28.97	84162.49	
CAT - Art Therapy Group	45 minutes	0	0.00	28.97	0.00	
CAT - Drama	45 minutes	0	0.00	28.97	0.00	
CAT - Music Therapy Group, up to 4 PPL	45 minutes	1	1.00	28.97	28.97	
CAT- Music Therapy w/ EXT	45 minutes	0	0.00	28.97	0.00	
CAT- Music Therapy w/ EXT (Remote)	45 minutes	0	0.00	28.97	0.00	
CAT - Dance Therapy w/ EXT	45 minutes	0	0.00	28.97	0.00	
CAT - Dance Therapy w/ EXT- Remote	45 minutes	0	0.00	28.97	0.00	
CAT - Drama Therapy w/ EXT	45 minutes	0	0.00	28.97	0.00	
CAT - Drama Therapy w/ EXT- Remote	45 minutes	0	0.00	28.97	0.00	
CAT - Dance Therapy Group w/ EXT	45 minutes	0	0.00	28.97	0.00	
CAT - Dance Therapy Group w/ EXT- Remote	45 minutes	0	0.00	28.97	0.00	
CAT - Drama Therapy					0.00	

GRAND TOTAL: 331524271.92

Total Estimated Unduplicated Participants: 1963

Factor D (Divide total by number of participants): 168886.54

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group w/ EXT	45 minutes	0	0.00	28.97		
CAT - Drama Therapy Group w/ EXT- Remote	45 minutes	0	0.00	28.97	0.00	
CAT- Art Therapy w/EXT	45 minutes	0	0.00	28.97	0.00	
CAT- Art Therapy w/EXT (Remote)	45 minutes	0	0.00	28.97	0.00	
CAT- Art Therapy Group EXT	45 minutes	0	0.00	28.97	0.00	
CAT- Art Therapy Group EXT (Remote)	45 minutes	0	0.00	28.97	0.00	
CAT- Dance Therapy (Remote)	45 minutes	0	0.00	28.97	0.00	
CAT- Dance Therapy Group	45 minutes	0	0.00	28.97	0.00	
CAT- Drama Therapy Remote	45 minutes	0	0.00	28.97	0.00	
CAT- Drama Therapy Group	45 minutes	0	0.00	28.97	0.00	
CAT- Music Therapy	45 minutes	78	9.85	28.97	22257.65	
CAT- Music Therapy (Remote)	45 minutes	78	9.85	28.97	22257.65	
CAT- Music Therapy Group w/EXT	45 minutes	0	0.00	28.97	0.00	
CAT- Music Therapy Group w/ EXT (Remote)	45 minutes	0	0.00	28.97	0.00	
Dental Total:						12036.58
Dental Services	visit	100	1.03	116.86	12036.58	
Family Training Total:						21009.49
Family Training - Remote	15 minutes	0	0.00	0.01	0.00	
Family Training - Non-Family	15 minutes	9	24.45	17.63	3879.48	
Family Training - Non-Family (Remote)	15 minutes	4	9.74	17.63	686.86	
Family Training - Professional	15 minutes	14	66.62	17.63	16443.15	
Family Training - Small Group Peer	15 minutes	0	0.00	9.69	0.00	
Family Training - Small Group Professional	15 minutes	0	0.00	7.11	0.00	

GRAND TOTAL: 331524271.92

Total Estimated Unduplicated Participants: 1963

Factor D (Divide total by number of participants): 168886.54

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Health Assessment and Coordination Total:						**0.00**
Health Assessment and Coordination Telehealth Service	monthly	0	0.00	0.01	**0.00**	
Host Home Total:						**10316011.19**
Host Home Residential Care - Basic (UA)	1 day	169	85.63	186.07	**2692706.42**	
Host Home Residential Care - Med (UB)	1 day	76	89.75	208.11	**1419518.31**	
Host Home Residential Care - High (UC)	1 day	116	91.25	270.54	**2863665.90**	
Host Home Residential Care - High (UD)	1 day	60	90.95	612.08	**3340120.56**	
Individualized Day Supports Total:						**11866064.09**
Individualized Day Support - 1:1	15 minutes	557	796.17	10.25	**4545533.57**	
Individualized Day Support 1:2	15 minutes	1620	624.15	7.24	**7320530.52**	
Occupational Therapy Total:						**236090.15**
Occupational Therapy	15 minutes	337	23.92	28.97	**233528.33**	
OT- Assessment Ongoing (Remote)	15 minutes	37	2.39	28.97	**2561.82**	
One-Time Transitional Services Total:						**5217.31**
One-Time Transitional Services	1 unit	1	1.00	5217.31	**5217.31**	
Parenting Supports Total:						**1181719.67**
Parenting Support - Peer	15 minutes	16	607.29	9.69	**94154.24**	
Parenting Support - Professional	15 minutes	80	665.50	17.61	**937556.40**	
Parenting Support - Small Group Peer	15 minutes	0	0.00	2.85	**0.00**	
Parenting Support - Small Group Professional	15 minutes	0	0.00	2.85	**0.00**	
Parenting Support - Individual Professional (Remote)	15 minutes	32	266.20	17.61	**150009.02**	
Personal Emergency Response System (PERS) Total:						**94.56**
PERS- Installation	flat rate	1	1.00	58.57	**58.57**	

GRAND TOTAL: 331524271.92

Total Estimated Unduplicated Participants: 1963

Factor D (Divide total by number of participants): 168886.54

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
PERS- Monthly Service	monthly	1	1.00	35.99	35.99	
Physical Therapy Total:						685949.34
Physical Therapy	15 minutes	729	32.48	28.97	685949.34	
Small Group Supported Employment Total:						1298093.67
SE Gp Job Training & Supports Professional	15 minutes	140	560.19	14.40	1129343.04	
SE Gp Job Training & Supports Professional (Remote)	15 minutes	8	56.02	3.86	1729.90	
SE Gp Job Training & Supports Paraprofessional	15 minutes	61	707.02	3.86	166474.93	
SE Gp Job Training & Supports Paraprofessional (Remote)	15 minutes	4	35.35	3.86	545.80	
Speech, Hearing and Language Services Total:						896275.31
Speech, Hearing and Language - Individual	15 minutes	796	36.74	28.97	847228.81	
Speech, Hearing and Language - Small Group	15 minutes	0	0.00	14.12	0.00	
Speech, Hearing and Language Assessment	15 minutes	77	17.61	28.97	39282.45	
Speech, Hearing and Language Assessment (Remote)	15 minutes	8	1.76	28.97	407.90	
Speech, Hearing and Language Service - Individual (Remote)	15 minutes	88	3.67	28.97	9356.15	
Supported Living with Transportation Total:						104831225.16
SL (1) 1:1 AON w/TRANS (R-ON)	1 day	12	4.30	775.19	39999.80	
SL (1) 1:1 AON w/TRANS (R-ON) +1	1 day	12	4.30	735.83	37968.83	
SL (1) 1:1 AON w/TRANS (R-ON) +2	1 day	12	4.30	632.43	32633.39	
SL(2) Basic Support Level 1 w/TRANS (R-ON)	1 day	4	15.75	429.54	27061.02	
SL(2)Basic Support Level 1 w/TRANS (R-ON) +1	1 day	4	15.75	412.83	26008.29	
SL(2)Basic Support Level 1 w/TRANS (R-ON) +2	1 day	4	15.75	387.72	24426.36	
SL(2) Inten Support					79514.26	

GRAND TOTAL: 331524271.92

Total Estimated Unduplicated Participants: 1963

Factor D (Divide total by number of participants): 168886.54

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 1 w/TRANS (R-ON)	1 day	29	4.18	655.95		
SL(2) Inten Support Level 1 w/TRANS (R-ON) +1	1 day	29	4.18	646.09	78319.03	
SL(2) Inten Support Level 1 w/TRANS (R-ON) +2	1 day	29	4.18	578.23	70093.04	
SL(2) Mod Support Level 1 w/TRANS (R-ON)	1 day	4	0.40	507.91	812.66	
SL(2) Mod Support Level 1 w/TRANS (R-ON) +1	1 day	4	0.40	506.74	810.78	
SL(2) Mod Support Level 1 w/TRANS (R-ON) +2	1 day	4	0.40	480.31	768.50	
SL(3) Basic Support Level 1 w/TRANS (R-ON)	1 day	0	0.00	330.35	0.00	
SL(3) Basic Support Level 1 w/TRANS (R-ON) +1	1 day	0	0.00	341.26	0.00	
SL(3) Basic Support Level 1 w/TRANS (R-ON) +2	1 day	0	0.00	339.00	0.00	
SL(3) Inten Support Level 1 w/TRANS (R-ON)	1 day	12	8.70	481.46	50264.42	
SL(3) Inten Support Level 1 w/TRANS (R-ON) +1	1 day	12	8.70	495.78	51759.43	
SL(3) Inten Support Level 1 w/TRANS (R-ON) +2	1 day	12	8.70	476.27	49722.59	
SL (3) Moderate Support Level 1 W/TRANS (R-ON)	1 day	4	42.00	445.64	74867.52	
SL (3) Moderate Support Level 1 W/TRANS (R-ON) + 1	1 day	4	42.00	461.99	77614.32	
SL (3) Moderate Support Level 1 W/TRANS (R-ON) + 2	1 day	4	42.00	453.96	76265.28	
SL 1 Res (Asleep ON) w/TRANS (UD-HI)	1 day	4	35.00	919.28	128699.20	
SL 1 Res (AON) w/TRANS (UC-HI)	1 day	196	86.05	919.28	15504392.62	
SL 1 Res (Periodic) w/ TRANS (U1 - HI)	15 minutes	167	2080.00	8.41	2921297.60	
SL 2 Res (Basic 1) w/ TRANS (U7 - HI)	1 day	4	63.00	490.20	123530.40	
SL 2 Res (Basic 2) w/ TRANS (U8 - HI)	1 day	623	53.08	490.51	16220596.71	
SL 2 Res (Moderate 1)					18165.12	

GRAND TOTAL: 331524271.92

Total Estimated Unduplicated Participants: 1963

Factor D (Divide total by number of participants): 168886.54

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
w/ Transportation (U9 - HI)	1 day	4	8.00	567.66		
SL 2 Res (Intensive 1) w/ Transportation (UB - HI)	1 day	502	83.70	717.30	30139081.02	
SL 2 Res (Moderate 2) w/ Transportation (UA - HI)	1 day	80	59.05	626.28	2958546.72	
SL 3 Intensive w/ LPN w/ Transportation (TE - HI)	1 day	34	87.28	664.26	1971204.84	
SL 3 Res (Basic 1) w/ Transportation (U1- HI)	1 day	0	0.00	330.35	0.00	
SL 3 Res (Basic 2) w/ Transportation (U2 - HI)	1 day	74	89.11	362.59	2390969.22	
SL 3 Res (Intensive 1) w/ Transportation (U5 - HI)	1 day	76	87.05	513.70	3398536.46	
Supported Living 3 Res (Intensive 2) w/ Transportation (U6 - HI)	1 day	464	91.25	587.05	24855697.00	
Supported Living 3 Res (Moderate 2) w/ Transportation (U4 - HI)	1 day	75	88.38	477.87	3167561.30	
Res - Moderate 1 w/ Transportation (U3 HI)	1 day	4	84.00	477.88	160567.68	
SL Periodic with transportation (Remote)	15 minutes	28	312.00	8.41	73469.76	
Supported Living Total:						61130845.42
SL (1) One to One Awake Overnight (R-ON)	1 day	8	4.13	616.62	20373.12	
SL (1) One to One Awake Overnight (R-ON) +1	15 minutes	8	4.13	577.26	19072.67	
SL (1) One to One Awake Overnight (R-ON) +2	1 day	8	4.13	473.85	15656.00	
SL (2) Basic Support Level 1 (R-ON)	1 day	4	14.73	336.69	19837.77	
SL (2) Basic Support Level 1 (R-ON) +1	1 day	4	14.73	319.98	18853.22	
SL (2) Basic Support Level 1 (R-ON) +2	1 day	4	14.73	294.87	17373.74	
SL (2) Inten Support Level 1 (R-ON)	1 day	12	3.90	563.10	26353.08	
SL (2) Inten Support Level 1 (R-ON) +1	1 day	12	3.90	553.24	25891.63	
SL (2) Inten Support					22715.78	

GRAND TOTAL: 331524271.92

Total Estimated Unduplicated Participants: 1963

Factor D (Divide total by number of participants): 168886.54

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 1 (R-ON) +2	1 day	12	3.90	485.38		
SL (2) Mod Support Level 1 (R-ON)	1 day	4	4.28	415.06	7105.83	
SL (2) Mod Support Level 1 (R-ON) +1	1 day	4	4.28	412.88	7068.51	
SL (2) Mod Support Level 1 (R-ON) +2	1 day	4	4.28	387.46	6633.32	
SL (3) Basic Support Level 1 (R-ON)	1 day	4	7.61	259.41	7896.44	
SL (3) Basic Support Level 1 (R-ON) +1	1 day	4	7.61	270.31	8228.24	
SL (3) Basic Support Level 1 (R-ON) +2	1 day	4	7.61	268.05	8159.44	
SL (3) Intens Support Level 1 (R-ON)	1 day	24	8.53	410.52	84041.65	
SL (3) Intens Support Level 1 (R-ON) + 1	1 day	24	8.53	424.84	86973.24	
SL (3) Intens Support Level 1 (R-ON) + 2	1 day	24	8.53	405.33	82979.16	
SL (3) Moderate Support Level (1) (R-ON)	1 day	4	42.00	374.69	62947.92	
SL (3) Moderate Support Level (1) (R-ON) + 1	1 day	4	42.00	391.05	65696.40	
SL (3) Moderate Support Level (1) (R-ON) + 2	1 day	4	42.00	383.02	64347.36	
SL Periodic	1 day	0	0.00	0.01	0.00	
SL 1 Res (Asleep ON-UD)	1 day	4	25.00	760.71	76071.00	
SL 1 Res (Awake ON-UC)	1 day	122	82.51	760.71	7657474.22	
SL 1 Res (Periodic- U1)	15 minutes	67	590.89	4.29	169839.51	
SL 2 Res (Basic 1-U7)	1 day	5	73.65	397.34	146320.46	
SL 2 Res Basic 2- U8)	1 day	410	86.08	397.66	14034534.85	
SL 2 Res (Intensive 1-UB)	1 day	235	78.02	624.45	11449103.42	
SL 2 Res (Moderate 1-U9)	1 day	24	85.66	474.81	976133.39	
SL 2 Res (Moderate 2-UA)	1 day	142	76.51	533.43	5795407.56	

GRAND TOTAL: 331524271.92

Total Estimated Unduplicated Participants: 1963

Factor D (Divide total by number of participants): 168886.54

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
SL 3 Intensive w/ LPN (U1-TE)	1 day	44	81.00	593.32	2114592.48	
SL 3 Res (Basic 1- U1)	1 day	9	76.06	291.64	199639.25	
SL 3 Res (Basic 2- U2)	1 day	47	89.14	291.64	1221849.11	
SL 3 Res (Intensive 1- U5)	1 day	156	85.29	442.76	5891028.06	
SL Res (Intensive 2- U6)	1 day	201	87.57	516.11	9084346.29	
SL 3 Res (Moderate 1- U3)	1 day	4	84.00	406.93	136728.48	
SL 3 Res (Moderate 2- U4)	15 minutes	36	90.77	406.93	1329733.30	
SL Periodic (Remote)	15 minutes	67	590.89	4.29	169839.51	
SL (Acute Care Hospital Setting)	15 minutes	0	0.00	1.00	0.00	
Wellness Services Total:						3082392.12
Wellness Services - Fitness Trainer Individual	15 minutes	1535	52.00	21.73	1734488.60	
Wellness Services - Fitness Trainer Group	15 minutes	14	52.00	13.04	9493.12	
Wellness Services - Bereavement Counseling	15 minutes	21	31.89	18.84	12616.96	
Wellness Services - Healthy Relationships	15 minutes	91	51.46	22.46	105177.04	
Wellness Services - Nutritional Counseling	15 minutes	1963	26.00	19.23	981460.74	
Wellness Services - Fitness Trainer Individual (Remote)	15 minutes	383	10.40	21.73	86554.94	
Wellness Services - Fitness Trainer Group (Remote)	15 minutes	4	10.40	13.04	542.46	
Wellness Services - Bereavement Counseling (Remote)	15 minutes	4	6.38	18.84	480.80	
Wellness Services - Healthy Relationships (Remote)	15 minutes	23	10.29	22.46	5315.61	
Wellness Services - Nutritional Counseling (Remote)	15 minutes	536	5.20	19.23	53597.86	
Wellness Services- Massage Therapy	15 minutes	99	52.00	18.00	92664.00	

GRAND TOTAL: 331524271.92

Total Estimated Unduplicated Participants: 1963

Factor D (Divide total by number of participants): 168886.54

Average Length of Stay on the Waiver: 356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**16303066.19**
Day Habilitation (remote)	15 minutes	174	131.66	3.59	**82242.74**	
Day Habilitation 1:6 (remote)	15 minutes	72	94.93	4.38	**29937.12**	
Day Habilitation 1:1	15 minutes	645	949.35	12.64	**7739860.68**	
Day Habilitation	15 minutes	988	877.76	6.96	**6035899.08**	
Day Habilitation Small Group	15 minutes	194	1121.67	10.07	**2191272.08**	
Day Habilitation w/ meals (1:1)	1 day	4	70.95	6.06	**1719.83**	
Small Group Day Hab 1:6 (Remote)	15 minutes	21	112.17	5.11	**12036.96**	
Day Hab w/ Meals delivered by Third Party Vendor	1 day	580	41.07	8.82	**210097.69**	
Employment Readiness Total:						**7794142.88**
Employment Readiness (Remote)	15 minutes	268	234.97	3.10	**195213.08**	
Pre-Vocational/Employment Readiness	15 minutes	1078	1174.85	6.00	**7598929.80**	
In-Home Supports Total:						**44479449.67**
High Intensive In-Home Supports	15 minutes	200	2920.00	7.96	**4648640.00**	
In-Home Supports	15 minutes	1983	2755.30	7.29	**39830809.67**	
In-Home Supports (Remote)	15 minutes	0	0.00	1.00	**0.00**	
In-Home Supports (Acute Care Hospital Setting)	15 minutes	0	0.00	1.00	**0.00**	

GRAND TOTAL: 371535282.60

Total Estimated Unduplicated Participants: 1983

Factor D (Divide total by number of participants): 187360.20

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						**28357041.20**
Res Hab 4 Intensive w/ 24 hr LPN (U1 TE)	1 day	42	45.21	723.33	**1373473.47**	
Res Hab 5-6 Intensive w/ 24 hr LPN (U2-HI)	1 day	44	91.25	610.10	**2449551.50**	
Resident Habilitation 4 Res - Basic (U1)	1 day	8	91.02	332.61	**242193.30**	
Resident Habilitation 4 Res - Enhanced (U3)	1 day	125	91.17	522.54	**5954996.48**	
Resident Habilitation 4 Res - Intensive (U4)	1 day	111	84.99	637.03	**6009670.95**	
Resident Habilitation 4 Res - Moderate (U2)	1 day	12	88.41	466.32	**494728.21**	
Resident Habilitation 5-6 Res - Basic (U5)	1 day	4	91.25	357.19	**130374.35**	
Res Hab 5-6 Res (Enhanced - U7)	1 day	83	91.25	463.88	**3513311.15**	
Resident Habilitation 5-6 Res - Intensive (U8)	1 day	100	88.96	602.65	**5361174.40**	
Res Hab 5-6 Res (Moderate- U6)	1 day	73	91.25	424.48	**2827567.40**	
Respite Total:						**3946397.64**
Respite - Hourly	15 minutes	505	547.69	6.90	**1908425.80**	
Respite - Daily	1 day	122	33.38	500.44	**2037971.84**	
Supported Employment Total:						**2606777.80**
Individual Supported Employment - Intake and Assessment Paraprofessional (Remote)	15 minutes	1	0.50	7.81	**3.90**	
Individual Supported Employment - Intake and Assessment Professional (Remote)	15 minutes	4	27.00	14.71	**1588.68**	
Individual Supported Employment - Job Placement Paraprofessional (Remote)	15 minutes	8	48.00	8.15	**3129.60**	
Individual Supported Employment - Job Placement Professional (Remote)	15 minutes	8	12.00	14.71	**1412.16**	
Individual Supported Employment - Training & Supports Paraprofessional	15 minutes	14	27.96	8.15	**3190.24**	

GRAND TOTAL: 371535282.60

Total Estimated Unduplicated Participants: 1983

Factor D (Divide total by number of participants): 187360.20

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(Remote)						
Individual Supported Employment - Training & Supports Professional (Remote)	15 minutes	28	33.67	126.12	118900.89	
Individual Supported Employment - Long Term Follow Along Paraprofessional (Remote)	15 minutes	4	11.05	8.15	360.23	
Long-Term Supported Employment - Follow Along	15 minutes	50	207.05	14.71	152285.28	
Long-Term Follow Along Paraprofessional	15 minutes	41	559.18	8.15	186850.00	
Supported Employment - Training & Supports Paraprofessional w/ EXT	15 minutes	0	0.00	14.71	0.00	
Supported Employment - Training & Supports Professional w/ EXT	15 minutes	0	0.00	14.71	0.00	
Training & Supports Professional w/ EXT (Remote)	15 minutes	0	0.00	8.15	0.00	
SE- Assessment Paraprofessional	15 minutes	1	1.00	8.15	8.15	
SE- Assessment Professional	15 minutes	4	108.00	14.71	6354.72	
SE- Placement Paraprofessional	15 minutes	38	240.00	8.15	74328.00	
SE- Placement Professional	15 minutes	163	240.00	14.71	575455.20	
SE- Training Paraprofessional	15 minutes	61	720.00	3.94	173044.80	
SE- Training Professional	15 minutes	152	585.64	14.71	1309444.19	
Long Term Follow Along Professional (Remote)	15 minutes	5	10.35	8.15	421.76	
Personal Care Services Total:						6.25
Personal Care	15 minutes	1	1.00	6.25	6.25	
Skilled Nursing Total:						1891731.50
Skilled Nursing - Visit/RN	15 minutes	1	1.00	17.55	17.55	
Skilled Nursing - Extended/RN	15 minutes	4	1436.04	17.55	100810.01	
Skilled Nursing - Initial Assessment	flat rate	0	0.00	140.44	0.00	

GRAND TOTAL: 371535282.60

Total Estimated Unduplicated Participants: 1983

Factor D (Divide total by number of participants): 187360.20

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled Nursing - Extended/LPN/LVN	15 minutes	32	3825.41	14.63	1790903.95	
Assistive Technology Services Total:						136288.00
Assistive Technology-Goods	item	20	1.00	5000.00	100000.00	
Assistive Technology (Remote)	15 minutes	0	0.00	28.35	0.00	
Assistive Technology-Services	15 minutes	160	8.00	28.35	36288.00	
Assistive Technology - Ongoing	15 minutes	0	0.00	1.00	0.00	
Assistive Technology-Ongoing (Remote)	15 minutes	0	0.00	1.00	0.00	
Assistive Technology-PERS (Installation)	item	0	0.00	59.86	0.00	
Assistive Technology-PERS (Monthly)	1 month	0	0.00	56.79	0.00	
Behavioral Supports Total:						13230976.60
Behavior Support - Diagnostic Assessment	flat rate	61	1.00	297.85	18168.85	
Behavior Support - Non-professional Services	15 minutes	386	3760.66	7.31	10611303.90	
Behavior Support - Paraprofessional Services	15 minutes	269	37.41	19.65	197743.65	
Behavior Support - Professional Services	15 minutes	1255	35.42	31.92	1418911.03	
Behavior Support - Diagnostic Assessment (Remote)	flat rate	40	0.40	297.85	4765.60	
Behavior Support - Non-professional Services (Remote)	15 minutes	99	742.77	7.47	549300.70	
Behavior Support - Paraprofessional Services (Remote)	15 minutes	179	14.97	19.65	52654.73	
Behavior Support - Professional (Remote)	15 minutes	836	14.17	31.92	378128.15	
Companion Services Total:						32309255.17
Companion Services Individual	15 minutes	1880	1928.36	6.41	23238280.69	
Companion Services Group	15 minutes	1965	1489.12	3.10	9070974.48	
Companion 1:2	15 minutes	0	0.00	1.00	0.00	

GRAND TOTAL: 371535282.60

Total Estimated Unduplicated Participants: 1983

Factor D (Divide total by number of participants): 187360.20

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Creative Arts Therapies Total:						**172738.89**
Creative Arts Therapies (CAT) - Dance	45 minutes	0	0.00	29.61	**0.00**	
CAT -Art (Remote)	45 minutes	41	7.16	29.61	**8692.31**	
CAT - Art	45 minutes	61	17.90	29.61	**32331.16**	
CAT - Art Therapy Group	45 minutes	0	0.00	29.61	**0.00**	
CAT - Drama	45 minutes	0	0.00	29.61	**0.00**	
CAT - Music Therapy Group, up to 4 PPL	45 minutes	1	24.00	29.61	**710.64**	
CAT- Music Therapy w/ EXT	45 minutes	0	0.00	29.61	**0.00**	
CAT- Music Therapy w/ EXT (Remote)	45 minutes	0	0.00	29.61	**0.00**	
CAT - Dance Therapy w/ EXT	45 minutes	0	0.00	29.61	**0.00**	
CAT - Dance Therapy w/ EXT- Remote	45 minutes	0	0.00	29.61	**0.00**	
CAT - Drama Therapy w/ EXT	45 minutes	0	0.00	29.61	**0.00**	
CAT - Drama Therapy w/ EXT- Remote	45 minutes	0	0.00	29.61	**0.00**	
CAT - Dance Therapy Group w/ EXT	45 minutes	0	0.00	29.61	**0.00**	
CAT - Dance Therapy Group w/ EXT- Remote	45 minutes	0	0.00	29.61	**0.00**	
CAT - Drama Therapy Group w/ EXT	45 minutes	0	0.00	29.61	**0.00**	
CAT - Drama Therapy Group w/ EXT- Remote	45 minutes	0	0.00	29.61	**0.00**	
CAT- Art Therapy w/EXT	45 minutes	0	0.00	29.61	**0.00**	
CAT- Art Therapy w/EXT (Remote)	45 minutes	0	0.00	29.61	**0.00**	
CAT- Art Therapy Group EXT	45 minutes	0	0.00	29.61	**0.00**	
CAT- Art Therapy Group EXT (Remote)	45 minutes	0	0.00	29.61	**0.00**	
CAT- Dance Therapy (Remote)	45 minutes	0	0.00	0.01	**0.00**	
CAT- Dance Therapy					**0.00**	

GRAND TOTAL: 371535282.60

Total Estimated Unduplicated Participants: 1983

Factor D (Divide total by number of participants): 187360.20

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group	45 minutes	0	0.00	29.61		
CAT- Drama Therapy Remote	45 minutes	0	0.00	29.61	0.00	
CAT- Drama Therapy Group	45 minutes	0	0.00	29.61	0.00	
CAT- Music Therapy	45 minutes	137	25.10	30.23	103951.90	
CAT- Music Therapy (Remote)	45 minutes	91	10.04	29.61	27052.88	
CAT- Music Therapy Group w/EXT	45 minutes	0	0.00	29.61	0.00	
CAT- Music Therapy Group w/ EXT (Remote)	45 minutes	0	0.00	29.61	0.00	
Dental Total:						0.00
Dental Services	visit	0	0.95	119.43	0.00	
Family Training Total:						32314.98
Family Training - Remote	15 minutes	10	28.28	18.01	5093.23	
Family Training - Non-Family	15 minutes	12	27.95	18.01	6040.55	
Family Training - Non-Family (Remote)	15 minutes	4	11.18	18.01	805.41	
Family Training - Professional	15 minutes	16	70.71	18.01	20375.79	
Family Training - Small Group Peer	15 minutes	0	0.00	9.90	0.00	
Family Training - Small Group Professional	15 minutes	0	0.00	7.27	0.00	
Health Assessment and Coordination Total:						0.00
Health Assessment and Coordination Telehealth Service	monthly	0	0.00	1.00	0.00	
Host Home Total:						10730475.29
Host Home Residential Care - Basic (UA)	1 day	174	85.74	190.17	2837100.59	
Host Home Residential Care - Med (UB)	1 day	76	90.71	212.68	1466207.41	
Host Home Residential Care - High (UC)	1 day	119	91.25	276.49	3002335.79	
Host Home Residential Care - High (UD)	1 day	60	91.25	625.54	3424831.50	

GRAND TOTAL: 371535282.60

Total Estimated Unduplicated Participants: 1983

Factor D (Divide total by number of participants): 187360.20

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individualized Day Supports Total:						**14305946.45**
Individualized Day Support - 1:1	15 minutes	697	831.69	10.48	**6075129.51**	
Individualized Day Support 1:2	15 minutes	1736	640.71	7.40	**8230816.94**	
Occupational Therapy Total:						**264687.64**
Occupational Therapy	15 minutes	353	25.11	29.61	**262458.01**	
OT- Assessment Ongoing (Remote)	15 minutes	30	2.51	29.61	**2229.63**	
One-Time Transitional Services Total:						**5000.00**
One-Time Transitional Services	1 unit	1	1.00	5000.00	**5000.00**	
Parenting Supports Total:						**1552594.28**
Parenting Support - Peer	15 minutes	19	659.44	9.90	**124040.66**	
Parenting Support - Professional	15 minutes	88	778.08	18.00	**1232478.72**	
Parenting Support - Small Group Peer	15 minutes	0	0.00	2.91	**0.00**	
Parenting Support - Small Group Professional	15 minutes	0	0.00	2.91	**0.00**	
Parenting Support - Individual Professional (Remote)	15 minutes	35	311.23	18.00	**196074.90**	
Personal Emergency Response System (PERS) Total:						**96.65**
PERS- Installation	flat rate	1	1.00	59.86	**59.86**	
PERS- Monthly Service	monthly	1	1.00	36.79	**36.79**	
Physical Therapy Total:						**760369.99**
Physical Therapy	15 minutes	770	33.35	29.61	**760370.00**	
Small Group Supported Employment Total:						**1480430.32**
SE Gp Job Training & Supports Professional	15 minutes	152	583.64	14.71	**1304972.35**	
SE Gp Job Training & Supports Professional (Remote)	15 minutes	8	58.56	3.94	**1845.81**	
SE Gp Job Training & Supports Paraprofessional	15 minutes	61	720.00	3.94	**173044.80**	

GRAND TOTAL: 371535282.60

Total Estimated Unduplicated Participants: 1983

Factor D (Divide total by number of participants): 187360.20

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
SE Gp Job Training & Supports Paraprofessional (Remote)	15 minutes	4	36.00	3.94	567.36	
Speech, Hearing and Language Services Total:						937196.10
Speech, Hearing and Language - Individual	15 minutes	808	36.84	29.61	881392.58	
Speech, Hearing and Language - Small Group	15 minutes	1	1.00	14.43	14.43	
Speech, Hearing and Language Assessment	15 minutes	86	17.87	29.61	45505.24	
Speech, Hearing and Language Assessment (Remote)	15 minutes	9	1.79	29.61	477.02	
Speech, Hearing and Language Service - Individual (Remote)	15 minutes	90	3.68	29.61	9806.83	
Supported Living with Transportation Total:						117993114.02
SL (1) 1:1 AON w/TRANS (R-ON)	1 day	12	4.35	792.25	41355.45	
SL (1) 1:1 AON w/TRANS (R-ON) +1	1 day	12	4.35	752.02	39255.44	
SL (1) 1:1 AON w/TRANS (R-ON) +2	1 day	12	4.35	646.34	33738.95	
SL(2) Basic Support Level 1 w/TRANS (R-ON)	1 day	4	15.75	438.99	27656.37	
SL(2)Basic Support Level 1 w/TRANS (R-ON) +1	1 day	4	15.75	421.91	26580.33	
SL(2)Basic Support Level 1 w/TRANS (R-ON) +2	1 day	4	15.75	396.25	24963.75	
SL(2) Inten Support Level 1 w/TRANS (R-ON)	1 day	32	4.54	670.38	97392.81	
SL(2) Inten Support Level 1 w/TRANS (R-ON) +1	1 day	32	4.54	660.31	95929.84	
SL(2) Inten Support Level 1 w/TRANS (R-ON) +2	15 minutes	32	4.54	590.95	85853.22	
SL(2) Mod Support Level 1 w/TRANS (R-ON)	1 day	4	0.40	519.09	830.54	
SL(2) Mod Support Level 1 w/TRANS (R-ON) +1	1 day	3	0.40	517.88	621.46	
SL(2) Mod Support Level 1 w/TRANS (R-ON) +2	1 day	4	0.40	490.88	785.41	
SL(3) Basic Support					0.00	

GRAND TOTAL: 371535282.60

Total Estimated Unduplicated Participants: 1983

Factor D (Divide total by number of participants): 187360.20

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Level 1 w/TRANS (R-ON)	1 day	0	0.00	337.62		
SL(3) Basic Support Level 1 w/TRANS (R-ON) +1	1 day	0	0.00	348.76	0.00	
SL(3) Basic Support Level 1 w/TRANS (R-ON) +2	1 day	0	0.00	346.46	0.00	
SL(3) Inten Support Level 1 w/TRANS (R-ON)	1 day	12	8.81	492.05	52019.53	
SL(3) Inten Support Level 1 w/TRANS (R-ON) +1	1 day	12	8.81	492.05	52019.53	
SL(3) Inten Support Level 1 w/TRANS (R-ON) +2	1 day	12	8.81	506.69	53567.27	
SL (3) Moderate Support Level 1 W/TRANS (R-ON)	1 day	4	42.00	455.44	76513.92	
SL (3) Moderate Support Level 1 W/TRANS (R-ON) + 1	1 day	4	42.00	472.15	79321.20	
SL (3) Moderate Support Level 1 W/TRANS (R-ON) + 2	1 day	4	42.00	463.95	77943.60	
SL 1 Res (Asleep ON) w/TRANS (UD-HI)	1 day	4	35.00	939.51	131531.40	
SL 1 Res (AON) w/TRANS (UC-HI)	1 day	209	87.06	939.51	17094891.79	
SL 1 Res (Periodic) w/ TRANS (U1 - HI)	15 minutes	170	2080.00	8.59	3037424.00	
SL 2 Res (Basic 1) w/ TRANS (U7 - HI)	1 day	4	63.00	500.98	126246.96	
SL 2 Res (Basic 2) w/ TRANS (U8 - HI)	1 day	674	53.66	501.30	18130436.89	
SL 2 Res (Moderate 1) w/ Transportation (U9 - HI)	1 day	4	8.00	580.15	18564.80	
SL 2 Res (Intensive 1) w/ Transportation (UB - HI)	1 day	530	90.88	733.08	35309824.51	
SL 2 Res (Moderate 2) w/ Transportation (UA - HI)	1 day	83	69.37	640.06	3685279.86	
SL 3 Intensive w/ LPN w/ Transportation (TE - HI)	1 day	32	90.98	678.87	1976434.96	
SL 3 Res (Basic 1) w/ Transportation (U1- HI)	1 day	1	1.00	337.62	337.62	
SL 3 Res (Basic 2) w/ Transportation (U2 - HI)	1 day	81	90.44	370.56	2714589.16	
SL 3 Res (Intensive 1)					3700200.00	

GRAND TOTAL: 371535282.60

Total Estimated Unduplicated Participants: 1983

Factor D (Divide total by number of participants): 187360.20

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
w/ Transportation (U5 - HI)	1 day	80	88.10	525.00		
Supported Living 3 Res (Intensive 2) w/ Transportation (U6 - HI)	1 day	499	91.25	599.97	27318883.99	
Supported Living 3 Res (Moderate 2) w/ Transportation (U4 - HI)	1 day	84	88.54	488.38	3632257.88	
Res - Moderate 1 w/ Transportation (U3 HI)	1 day	4	84.00	488.39	164099.04	
SL Periodic with transportation (Remote)	15 minutes	32	312.00	8.59	85762.56	
Supported Living Total:						68862109.16
SL (1) One to One Awake Overnight (R-ON)	1 day	8	4.21	630.18	21224.46	
SL (1) One to One Awake Overnight (R-ON) +1	15 minutes	8	4.21	589.96	19869.85	
SL (1) One to One Awake Overnight (R-ON) +2	1 day	8	4.21	484.28	16310.55	
SL (2) Basic Support Level 1 (R-ON)	1 day	4	14.72	344.09	20260.02	
SL (2) Basic Support Level 1 (R-ON) +1	1 day	4	14.72	327.02	19254.94	
SL (2) Basic Support Level 1 (R-ON) +2	1 day	4	14.72	301.36	17744.08	
SL (2) Inten Support Level 1 (R-ON)	1 day	12	4.03	575.49	27830.70	
SL (2) Inten Support Level 1 (R-ON) +1	1 day	12	4.03	565.41	27343.23	
SL (2) Inten Support Level 1 (R-ON) +2	1 day	12	4.03	496.06	23989.46	
SL (2) Mod Support Level 1 (R-ON)	1 day	4	4.29	424.19	7279.10	
SL (2) Mod Support Level 1 (R-ON) +1	1 day	4	4.29	422.99	7258.51	
SL (2) Mod Support Level 1 (R-ON) +2	1 day	4	4.29	395.98	6795.02	
SL (3) Basic Support Level 1 (R-ON)	1 day	4	4.29	424.19	7279.10	
SL (3) Basic Support Level 1 (R-ON) +1	1 day	4	4.29	422.99	7258.51	
SL (3) Basic Support Level 1 (R-ON) +2	1 day	4	4.29	395.98	6795.02	

GRAND TOTAL: 371535282.60

Total Estimated Unduplicated Participants: 1983

Factor D (Divide total by number of participants): 187360.20

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
SL (3) Intens Support Level 1 (R-ON)	1 day	24	8.57	419.55	86293.04	
SL (3) Intens Support Level 1 (R-ON) + 1	1 day	24	8.57	434.18	89302.14	
SL (3) Intens Support Level 1 (R-ON) + 2	1 day	24	8.57	414.25	85202.94	
SL (3) Moderate Support Level (1) (R-ON)	1 day	4	42.00	382.94	64333.92	
SL (3) Moderate Support Level (1) (R-ON) + 1	1 day	4	42.00	399.65	67141.20	
SL (3) Moderate Support Level (1) (R-ON) + 2	1 day	4	42.00	391.44	65761.92	
SL Periodic	15 minutes	312	2990.52	7.74	7221746.94	
SL 1 Res (Asleep ON-UD)	1 day	4	25.00	777.44	77744.00	
SL 1 Res (Awake ON-UC)	1 day	117	84.23	777.44	7661601.23	
SL 1 Res (Periodic- U1)	1 day	0	0.00	0.01	0.00	
SL 2 Res (Basic 1-U7)	1 day	5	73.58	406.08	149396.83	
SL 2 Res Basic 2- U8)	1 day	371	86.54	406.41	13048337.64	
SL 2 Res (Intensive 1-UB)	1 day	224	80.50	638.19	11507842.08	
SL 2 Res (Moderate 1-U9)	1 day	24	85.75	485.25	998644.50	
SL 2 Res (Moderate 2-UA)	1 day	152	76.82	545.17	6365753.83	
SL 3 Intensive w/ LPN (U1-TE)	1 day	44	86.84	606.37	2316915.52	
SL 3 Res (Basic 1- U1)	1 day	11	76.40	298.06	250489.62	
SL 3 Res (Basic 2- U2)	1 day	53	91.25	298.06	1441492.68	
SL 3 Res (Intensive 1-U5)	1 day	160	85.68	452.50	6203232.00	
SL Res (Intensive 2-U6)	1 day	197	88.23	527.46	9167945.77	
SL 3 Res (Moderate 1-U3)	1 day	4	84.00	415.88	139735.68	
SL 3 Res (Moderate 2-U4)	15 minutes	36	91.25	415.88	1366165.80	

GRAND TOTAL: 371535282.60

Total Estimated Unduplicated Participants: 1983

Factor D (Divide total by number of participants): 187360.20

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
SL Periodic (Remote)	15 minutes	96	597.20	4.37	250537.34	
SL (Acute Care Hospital Setting)	15 minutes	0	0.00	1.00	0.00	
Wellness Services Total:						3383075.92
Wellness Services - Fitness Trainer Individual	15 minutes	1684	52.00	22.20	1944009.60	
Wellness Services - Fitness Trainer Group	15 minutes	16	52.00	13.33	11090.56	
Wellness Services - Bereavement Counseling	15 minutes	23	31.89	19.25	14119.30	
Wellness Services - Healthy Relationships	15 minutes	104	52.00	22.96	124167.68	
Wellness Services - Nutritional Counseling	15 minutes	1983	26.00	19.65	1013114.70	
Wellness Services - Fitness Trainer Individual (Remote)	15 minutes	421	10.40	22.20	97200.48	
Wellness Services - Fitness Trainer Group (Remote)	15 minutes	4	10.40	13.33	554.53	
Wellness Services - Bereavement Counseling (Remote)	15 minutes	50	6.38	19.25	6140.75	
Wellness Services - Healthy Relationships (Remote)	15 minutes	26	10.40	22.96	6208.38	
Wellness Services - Nutritional Counseling (Remote)	15 minutes	581	5.20	19.65	59366.58	
Wellness Services- Massage Therapy	15 minutes	112	52.00	18.39	107103.36	

GRAND TOTAL: 371535282.60

Total Estimated Unduplicated Participants: 1983

Factor D (Divide total by number of participants): 187360.20

Average Length of Stay on the Waiver: 356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver.*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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**7895062.40**
Day Habilitation (remote)	15 minutes	25	424.73	4.29	**45552.29**	
Day Habilitation 1:6 (remote)	15 minutes	8	352.80	5.35	**15099.84**	
Day Habilitation 1:1	15 minutes	74	3527.95	15.43	**4028283.87**	
Day Habilitation	15 minutes	174	707.88	8.30	**1022320.30**	
Day Habilitation Small Group	15 minutes	59	3634.38	12.30	**2637469.57**	
Day Habilitation w/ meals (1:1)	1 day	82	165.69	9.52	**129344.24**	
Small Group Day Hab 1:6 (Remote)	15 minutes	6	363.44	6.24	**13607.19**	
Day Hab w/ Meals delivered by Third Party Vendor	1 day	2	258.80	6.54	**3385.10**	
Employment Readiness Total:						**557270.39**
Employment Readiness (Remote)	15 minutes	7	435.74	3.70	**11285.67**	
Pre-Vocational/Employment Readiness	15 minutes	35	2178.71	7.16	**545984.73**	
In-Home Supports Total:						**41928135.63**
High Intensive In-Home Supports	15 minutes	56	9488.06	9.50	**5047647.92**	
In-Home Supports	15 minutes	531	7842.37	8.69	**36187753.70**	
In-Home Supports (Remote)	15 minutes	1	1568.47	8.69	**13630.00**	
In-Home Supports (Acute Care Hospital Setting)	15 minutes	15	5760.00	7.86	**679104.00**	
Residential Habilitation Total:						**18050074.69**
Res Hab 4 Intensive w/ 24 hr LPN (U1 TE)	1 day	1	180.83	799.45	**144564.54**	
Res Hab 5-6 Intensive w/ 24 hr LPN (U2-HI)	1 day	5	365.00	676.47	**1234557.75**	
Resident Habilitation 4 Res - Basic (U1)	1 day	8	316.79	377.11	**955717.42**	
Resident Habilitation 4 Res - Enhanced (U3)	1 day	28	307.79	597.43	**5148723.43**	
Resident Habilitation 4 Res - Intensive (U4)	1 day		285.54	730.41	**6673960.68**	

GRAND TOTAL: 386049145.07

Total Estimated Unduplicated Participants: 2003

Factor D (Divide total by number of participants): 192735.47

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		32				
Resident Habilitation 4 Res - Moderate (U2)	1 day	12	254.05	530.36	1616855.50	
Resident Habilitation 5-6 Res - Basic (U5)	1 day	1	365.00	403.46	147262.90	
Res Hab 5-6 Res (Enhanced - U7)	1 day	1	365.00	528.23	192803.95	
Resident Habilitation 5-6 Res - Intensive (U8)	1 day	5	365.00	685.04	1250198.00	
Res Hab 5-6 Res (Moderate- U6)	1 day	4	356.09	481.22	685430.52	
Respite Total:						2917284.71
Respite - Hourly	15 minutes	143	1997.32	8.23	2350625.93	
Respite - Daily	1 day	15	63.27	597.08	566658.77	
Supported Employment Total:						5996894.29
Individual Supported Employment - Intake and Assessment Paraprofessional (Remote)	15 minutes	1	2.00	8.04	16.08	
Individual Supported Employment - Intake and Assessment Professional (Remote)	15 minutes	1	108.00	15.92	1719.36	
Individual Supported Employment - Job Placement Paraprofessional (Remote)	15 minutes	1	192.00	9.73	1868.16	
Individual Supported Employment - Job Placement Professional (Remote)	15 minutes	1	48.00	15.87	761.76	
Individual Supported Employment - Training & Supports Paraprofessional (Remote)	15 minutes	3	80.30	9.73	2343.96	
Individual Supported Employment - Training & Supports Professional (Remote)	15 minutes	10	196.28	15.87	31149.64	
Individual Supported Employment - Long Term Follow Along Paraprofessional (Remote)	15 minutes	1	36.94	9.73	359.43	
Long-Term Supported Employment - Follow Along	15 minutes	1	694.67	4.70	3264.95	

GRAND TOTAL: 386049145.07

Total Estimated Unduplicated Participants: 2003

Factor D (Divide total by number of participants): 192735.47

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Long-Term Follow Along Paraprofessional	15 minutes	11	738.84	9.73	79078.05	
Supported Employment - Training & Supports Paraprofessional w/ EXT	15 minutes	71	1605.94	9.73	1109431.53	
Supported Employment - Training & Supports Professional w/ EXT	15 minutes	106	1962.84	15.87	3301928.70	
Training & Supports Professional w/ EXT (Remote)	15 minutes	1	1.00	15.87	15.87	
SE- Assessment Paraprofessional	15 minutes	1	4.00	8.82	35.28	
SE- Assessment Professional	15 minutes	1	432.00	15.92	6877.44	
SE- Placement Paraprofessional	15 minutes	3	960.00	9.73	28022.40	
SE- Placement Professional	15 minutes	17	960.00	15.87	258998.40	
SE- Training Paraprofessional	15 minutes	71	1605.94	9.73	1109431.53	
SE- Training Professional	15 minutes	7	1872.09	4.70	61591.76	
Long Term Follow Along Professional (Remote)	15 minutes	0	0.00	1.00	0.00	
Personal Care Services Total:						6.76
Personal Care	15 minutes	1	1.00	6.76	6.76	
Skilled Nursing Total:						661357.45
Skilled Nursing - Visit/RN	15 minutes	1	1.00	19.00	19.00	
Skilled Nursing - Extended/RN	15 minutes	1	6047.30	19.00	114898.70	
Skilled Nursing - Initial Assessment	flat rate	1	1.00	151.97	151.97	
Skilled Nursing - Extended/LPN/LVN	15 minutes	5	6959.08	15.70	546287.78	
Assistive Technology Services Total:						139859.69
Assistive Technology-Goods	item	18	64.00	32.62	37578.24	
Assistive Technology (Remote)	15 minutes	2	6.40	32.63	417.66	
Assistive Technology-Services	15 minutes	0	0.00	32.62	0.00	

GRAND TOTAL: 386049145.07

Total Estimated Unduplicated Participants: 2003

Factor D (Divide total by number of participants): 192735.47

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology - Ongoing	15 minutes	31	100.00	32.72	101432.00	
Assistive Technology- Ongoing (Remote)	15 minutes	1	10.00	32.72	327.20	
Assistive Technology- PERS (Installation)	item	1	1.00	64.78	64.78	
Assistive Technology- PERS (Monthly)	1 month	1	1.00	39.81	39.81	
Behavioral Supports Total:						20436555.39
Behavior Support - Diagnostic Assessment	flat rate	13	4.00	355.37	18479.24	
Behavior Support - Non-professional Services	15 minutes	107	17757.53	8.91	16929496.38	
Behavior Support - Paraprofessional Services	15 minutes	55	155.84	23.45	200994.64	
Behavior Support - Professional Services	15 minutes	446	129.70	38.08	2202783.30	
Behavior Support - Diagnostic Assessment (Remote)	flat rate	5	1.60	355.37	2842.96	
Behavior Support - Non-professional Services (Remote)	15 minutes	22	3551.51	8.91	696166.99	
Behavior Support - Paraprofessional Services (Remote)	15 minutes	22	62.34	23.45	32161.21	
Behavior Support - Professional (Remote)	15 minutes	179	51.88	38.08	353630.68	
Companion Services Total:						15793009.55
Companion Services Individual	15 minutes	279	4807.52	7.65	10260930.31	
Companion Services Group	15 minutes	64	3895.32	4.36	1086950.09	
Companion 1:2	15 minutes	166	4807.52	5.57	4445129.14	
Creative Arts Therapies Total:						150180.04
Creative Arts Therapies (CAT) - Dance	45 minutes	1	1.00	31.96	31.96	
CAT -Art (Remote)	45 minutes	1	28.80	31.96	920.45	
CAT - Art	45 minutes	1	72.00	31.96	2301.12	
CAT - Art Therapy Group	45 minutes	1	72.00	31.96	2301.12	

GRAND TOTAL: 386049145.07

Total Estimated Unduplicated Participants: 2003

Factor D (Divide total by number of participants): 192735.47

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CAT - Drama	45 minutes	1	1.00	31.96	31.96	
CAT - Music Therapy Group, up to 4 PPL	45 minutes	7	72.00	31.96	16107.84	
CAT- Music Therapy w/ EXT	45 minutes	37	72.00	31.96	85141.44	
CAT- Music Therapy w/ EXT (Remote)	45 minutes	5	87.00	31.96	13902.60	
CAT - Dance Therapy w/ EXT	45 minutes	1	72.00	31.96	2301.12	
CAT - Dance Therapy w/ EXT- Remote	45 minutes	1	14.40	31.96	460.22	
CAT - Drama Therapy w/ EXT	45 minutes	1	72.00	31.96	2301.12	
CAT - Drama Therapy w/ EXT- Remote	45 minutes	1	28.80	31.96	920.45	
CAT - Dance Therapy Group w/ EXT	45 minutes	1	72.00	31.96	2301.12	
CAT - Dance Therapy Group w/ EXT- Remote	45 minutes	1	14.40	31.96	460.22	
CAT - Drama Therapy Group w/ EXT	45 minutes	1	72.00	31.96	2301.12	
CAT - Drama Therapy Group w/ EXT- Remote	45 minutes	1	28.80	31.96	920.45	
CAT- Art Therapy w/EXT	45 minutes	1	72.00	31.96	2301.12	
CAT- Art Therapy w/EXT (Remote)	45 minutes	1	28.80	31.96	920.45	
CAT- Art Therapy Group EXT	45 minutes	1	72.00	31.96	2301.12	
CAT- Art Therapy Group EXT (Remote)	45 minutes	1	14.00	31.96	447.44	
CAT- Dance Therapy (Remote)	45 minutes	1	14.40	31.96	460.22	
CAT- Dance Therapy Group	45 minutes	1	72.00	31.96	2301.12	
CAT- Drama Therapy Remote	45 minutes	1	28.80	31.96	920.45	
CAT- Drama Therapy Group	45 minutes	1	72.00	31.96	2301.12	
CAT- Music Therapy	45 minutes	1	72.00	31.96	2301.12	
CAT- Music Therapy (Remote)	45 minutes	1	14.40	31.96	460.22	
CAT- Music Therapy					2301.12	

GRAND TOTAL: 386049145.07

Total Estimated Unduplicated Participants: 2003

Factor D (Divide total by number of participants): 192735.47

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group w/EXT	45 minutes	1	72.00	31.96		
CAT- Music Therapy Group w/ EXT (Remote)	45 minutes	1	14.40	31.96	460.22	
Dental Total:						0.00
Dental Services	visit	0	0.00	129.24	0.00	
Family Training Total:						9041.36
Family Training - Remote	15 minutes	1	119.69	21.49	2572.14	
Family Training - Non-Family	15 minutes	1	1.00	19.49	19.49	
Family Training - Non-Family (Remote)	15 minutes	1	1.00	19.49	19.49	
Family Training - Professional	15 minutes	1	299.22	21.49	6430.24	
Family Training - Small Group Peer	15 minutes	0	0.00	10.72	0.00	
Family Training - Small Group Professional	15 minutes	0	0.00	7.86	0.00	
Health Assessment and Coordination Total:						119142.36
Health Assessment and Coordination Telehealth Service	monthly	321	12.00	30.93	119142.36	
Host Home Total:						13245338.54
Host Home Residential Care - Basic (UA)	1 day	36	351.68	226.90	2872662.91	
Host Home Residential Care - Med (UB)	1 day	23	330.97	253.76	1931699.79	
Host Home Residential Care - High (UC)	1 day	31	355.39	329.88	3634317.65	
Host Home Residential Care - High (UD)	1 day	18	357.79	746.35	4806658.20	
Individualized Day Supports Total:						26559065.27
Individualized Day Support - 1:1	15 minutes	163	4308.44	12.50	8778446.50	
Individualized Day Support 1:2	15 minutes	497	4051.63	8.83	17780618.77	
Occupational Therapy Total:						387058.93
Occupational Therapy	15 minutes	123	97.51	31.96	383319.61	
OT- Assessment					3739.32	

GRAND TOTAL: 386049145.07

Total Estimated Unduplicated Participants: 2003

Factor D (Divide total by number of participants): 192735.47

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Ongoing (Remote)	15 minutes	12	9.75	31.96		
One-Time Transitional Services Total:						**5000.00**
One-Time Transitional Services	1 unit	1	1.00	5000.00	**5000.00**	
Parenting Supports Total:						**916201.46**
Parenting Support - Peer	15 minutes	5	2379.63	11.82	**140636.13**	
Parenting Support - Professional	15 minutes	10	3223.76	21.48	**692463.65**	
Parenting Support - Small Group Peer	15 minutes	1	1.00	3.15	**3.15**	
Parenting Support - Small Group Professional	15 minutes	1	1.00	3.15	**3.15**	
Parenting Support - Individual Professional (Remote)	15 minutes	3	1289.50	21.48	**83095.38**	
Personal Emergency Response System (PERS) Total:						**0.00**
PERS- Installation	flat rate	0	0.00	64.78	**0.00**	
PERS- Monthly Service	monthly	0	0.00	39.81	**0.00**	
Physical Therapy Total:						**701726.54**
Physical Therapy	15 minutes	180	121.98	31.96	**701726.54**	
Small Group Supported Employment Total:						**1149.13**
SE Gp Job Training & Supports Professional	15 minutes	1	1.00	1.00	**1.00**	
SE Gp Job Training & Supports Professional (Remote)	15 minutes	1	150.47	4.70	**707.21**	
SE Gp Job Training & Supports Paraprofessional	15 minutes	1	1.00	1.00	**1.00**	
SE Gp Job Training & Supports Paraprofessional (Remote)	15 minutes	1	93.60	4.70	**439.92**	
Speech, Hearing and Language Services Total:						**36498.92**
Speech, Hearing and Language - Individual	15 minutes	1	1.00	31.96	**31.96**	
Speech, Hearing and Language - Small Group	15 minutes	1	1.00	15.62	**15.62**	
Speech, Hearing and					**36027.55**	

GRAND TOTAL: 386049145.07

Total Estimated Unduplicated Participants: 2003

Factor D (Divide total by number of participants): 192735.47

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Language Assessment	15 minutes	17	66.31	31.96		
Speech, Hearing and Language Assessment (Remote)	15 minutes	2	6.63	31.96	423.79	
Speech, Hearing and Language Service - Individual (Remote)	15 minutes	0	0.00	31.96	0.00	
Supported Living with Transportation Total:						189379239.62
SL (1) 1:1 AON w/TRANS (R-ON)	1 day	3	15.91	919.83	43903.49	
SL (1) 1:1 AON w/TRANS (R-ON) +1	1 day	3	15.91	871.17	41580.94	
SL (1) 1:1 AON w/TRANS (R-ON) +2	1 day	3	15.91	743.98	35510.17	
SL(2) Basic Support Level 1 w/TRANS (R-ON)	1 day	1	70.38	504.40	35499.67	
SL(2)Basic Support Level 1 w/TRANS (R-ON) +1	1 day	1	70.38	485.62	34177.94	
SL(2)Basic Support Level 1 w/TRANS (R-ON) +2	1 day	1	70.38	455.00	32022.90	
SL(2) Inten Support Level 1 w/TRANS (R-ON)	1 day	10	15.66	774.01	121209.97	
SL(2) Inten Support Level 1 w/TRANS (R-ON) +1	1 day	10	15.66	761.99	119327.63	
SL(2) Inten Support Level 1 w/TRANS (R-ON) +2	1 day	10	15.66	679.27	106373.68	
SL(2) Mod Support Level 1 w/TRANS (R-ON)	1 day	1	18.25	596.44	10885.03	
SL(2) Mod Support Level 1 w/TRANS (R-ON) +1	1 day	1	18.25	595.00	10858.75	
SL(2) Mod Support Level 1 w/TRANS (R-ON) +2	1 day	1	18.25	562.79	10270.92	
SL(3) Basic Support Level 1 w/TRANS (R-ON)	1 day	1	1.00	365.35	365.35	
SL(3) Basic Support Level 1 w/TRANS (R-ON) +1	1 day	1	1.00	377.41	377.41	
SL(3) Basic Support Level 1 w/TRANS (R-ON) +2	1 day	1	1.00	374.91	374.91	
SL(3) Inten Support Level 1 w/TRANS (R-ON)	1 day	2	31.69	565.23	35824.28	
SL(3) Inten Support Level 1 w/TRANS (R-					203119.91	

GRAND TOTAL: 386049145.07

Total Estimated Unduplicated Participants: 2003

Factor D (Divide total by number of participants): 192735.47

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
ON) +1	1 day	11	31.69	582.69		
SL(3) Inten Support Level 1 w/TRANS (R-ON) +2	1 day	2	31.69	558.91	35423.72	
SL (3) Moderate Support Level 1 W/TRANS (R-ON)	1 day	1	168.00	521.56	87622.08	
SL (3) Moderate Support Level 1 W/TRANS (R-ON) + 1	1 day	1	168.00	541.49	90970.32	
SL (3) Moderate Support Level 1 W/TRANS (R-ON) + 2	1 day	1	168.00	531.48	89288.64	
SL 1 Res (Asleep ON) w/TRANS (UD-HI)	1 day	3	249.90	1094.81	820779.06	
SL 1 Res (AON) w/TRANS (UC-HI)	1 day	76	318.23	1094.81	26478505.36	
SL 1 Res (Periodic) w/ TRANS (U1 - HI)	15 minutes	62	10824.68	10.03	6731435.50	
SL 2 Res (Basic 1) w/ TRANS (U7 - HI)	1 day	5	281.53	578.01	813635.78	
SL 2 Res (Basic 2) w/ TRANS (U8 - HI)	1 day	173	333.23	578.35	33341177.70	
SL 2 Res (Moderate 1) w/ Transportation (U9 - HI)	1 day	3	365.00	669.27	732850.65	
SL 2 Res (Intensive 1) w/ Transportation (UB - HI)	1 day	226	313.27	848.58	60078632.39	
SL 2 Res (Moderate 2) w/ Transportation (UA - HI)	1 day	29	310.28	741.56	6672645.87	
SL 3 Intensive w/ LPN w/ Transportation (TE - HI)	1 day	12	328.86	682.90	2694941.93	
SL 3 Res (Basic 1) w/ Transportation (U1- HI)	1 day	1	270.33	424.48	114749.68	
SL 3 Res (Basic 2) w/ Transportation (U2 - HI)	1 day	11	365.00	424.48	1704287.20	
SL 3 Res (Intensive 1) w/ Transportation (U5 - HI)	1 day	31	316.88	604.53	5938467.46	
Supported Living 3 Res (Intensive 2) w/ Transportation (U6 - HI)	1 day	164	338.10	693.96	38478971.66	
Supported Living 3 Res (Moderate 2) w/ Transportation (U4 - HI)	1 day	21	280.03	560.85	3298151.34	
Res - Moderate 1 w/ Transportation (U3 HI)	1 day	1	336.00	560.86	188448.96	

GRAND TOTAL: 386049145.07

Total Estimated Unduplicated Participants: 2003

Factor D (Divide total by number of participants): 192735.47

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
SL Periodic with transportation (Remote)	15 minutes	9	1623.70	10.03	146571.40	
Supported Living Total:						36299909.21
SL (1) One to One Awake Overnight (R-ON)	1 day	1	10.17	728.66	7410.47	
SL (1) One to One Awake Overnight (R-ON) +1	1 day	1	10.17	680.00	6915.60	
SL (1) One to One Awake Overnight (R-ON) +2	1 day	1	10.17	552.81	5622.08	
SL (2) Basic Support Level 1 (R-ON)	1 day	1	27.29	393.35	10734.52	
SL (2) Basic Support Level 1 (R-ON) +1	1 day	1	27.29	374.57	10222.02	
SL (2) Basic Support Level 1 (R-ON) +2	1 day	1	27.29	343.96	9386.67	
SL (2) Inten Support Level 1 (R-ON)	1 day	1	15.32	662.97	10156.70	
SL (2) Inten Support Level 1 (R-ON) +1	1 day	1	15.32	650.95	9972.55	
SL (2) Inten Support Level 1 (R-ON) +2	1 day	1	15.32	568.22	8705.13	
SL (2) Mod Support Level 1 (R-ON)	1 day	1	17.91	485.39	8693.33	
SL (2) Mod Support Level 1 (R-ON) +1	1 day	4	17.91	483.95	34670.18	
SL (2) Mod Support Level 1 (R-ON) +2	1 day	1	17.91	451.74	8090.66	
SL (3) Basic Support Level 1 (R-ON)	1 day	1	16.19	300.84	4870.60	
SL (3) Basic Support Level 1 (R-ON) +1	1 day	1	16.19	314.13	5085.76	
SL (3) Basic Support Level 1 (R-ON) +2	1 day	1	16.19	311.38	5041.24	
SL (3) Intens Support Level 1 (R-ON)	1 day	2	32.90	480.89	31642.56	
SL (3) Intens Support Level 1 (R-ON) + 1	1 day	2	32.90	498.35	32791.43	
SL (3) Intens Support Level 1 (R-ON) + 2	1 day	2	32.90	474.57	31226.71	
SL (3) Moderate Support Level (1) (R-ON)	1 day	4	168.00	437.22	293811.84	
SL (3) Moderate Support Level (1) (R-	1 day	1	168.00	457.15	76801.20	

GRAND TOTAL: 386049145.07

Total Estimated Unduplicated Participants: 2003

Factor D (Divide total by number of participants): 192735.47

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
ON) + 1						
SL (3) Moderate Support Level (1) (R-ON) + 2	1 day	1	168.00	447.14	75119.52	
SL Periodic	1 day	7	1925.22	5.23	70482.30	
SL 1 Res (Asleep ON-UD)	1 day	1	305.41	903.64	275980.69	
SL 1 Res (Awake ON-UC)	1 day	42	203.39	903.64	7719236.26	
SL 1 Res (Periodic- U1)	15 minutes	38	9626.11	9.23	3376261.82	
SL 2 Res (Basic 1-U7)	1 day	1	136.47	466.96	63726.03	
SL 2 Res Basic 2- U8)	1 day	42	203.39	467.30	3991854.17	
SL 2 Res (Intensive 1-UB)	1 day	28	306.30	737.53	6325352.29	
SL 2 Res (Moderate 1-U9)	1 day	2	358.27	558.22	399986.96	
SL 2 Res (Moderate 2-UA)	1 day	5	365.00	630.51	1150680.75	
SL 3 Intensive w/ LPN (U1-TE)	1 day	1	110.00	663.55	72990.50	
SL 3 Res (Basic 1- U1)	1 day	2	161.89	340.14	110130.53	
SL 3 Res (Basic 2- U2)	1 day	5	236.51	340.14	402232.56	
SL 3 Res (Intensive 1-U5)	1 day	30	328.96	520.19	5133651.07	
SL Res (Intensive 2-U6)	1 day	29	316.04	609.62	5587264.84	
SL 3 Res (Moderate 1-U3)	1 day	1	336.00	476.52	160110.72	
SL 3 Res (Moderate 2-U4)	1 day	1	28.00	476.52	13342.56	
SL Periodic (Remote)	15 minutes	8	1925.20	5.23	80550.37	
SL (Acute Care Hospital Setting)	15 minutes	15	5760.00	7.86	679104.00	
Wellness Services Total:						3864082.73
Wellness Services - Fitness Trainer Individual	15 minutes	538	192.90	23.96	2486573.59	
Wellness Services - Fitness Trainer Group	15 minutes		207.87	14.38	2989.17	

GRAND TOTAL: 386049145.07

Total Estimated Unduplicated Participants: 2003

Factor D (Divide total by number of participants): 192735.47

Average Length of Stay on the Waiver: 356

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1				
Wellness Services - Bereavement Counseling	15 minutes	5	397.50	20.77	41280.38	
Wellness Services - Healthy Relationships	15 minutes	10	182.40	24.77	45180.48	
Wellness Services - Nutritional Counseling	15 minutes	584	83.87	21.20	1038377.70	
Wellness Services - Fitness Trainer Individual (Remote)	15 minutes	107	38.58	23.96	98908.32	
Wellness Services - Fitness Trainer Group (Remote)	15 minutes	0	1.00	14.38	0.00	
Wellness Services - Bereavement Counseling (Remote)	15 minutes	1	1.00	20.77	20.77	
Wellness Services - Healthy Relationships (Remote)	15 minutes	2	36.48	24.77	1807.22	
Wellness Services - Nutritional Counseling (Remote)	15 minutes	117	16.77	21.20	41596.31	
Wellness Services- Massage Therapy	15 minutes	26	208.00	19.85	107348.80	

GRAND TOTAL: 386049145.07
Total Estimated Unduplicated Participants: 2003
Factor D (Divide total by number of participants): 192735.47
Average Length of Stay on the Waiver: 356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						11620893.58
Day Habilitation (remote)	15 minutes	25	437.60	4.54	49667.60	
Day Habilitation 1:6 (remote)	15 minutes	8	353.60	5.71	16152.45	

GRAND TOTAL: 408511890.45
Total Estimated Unduplicated Participants: 2023
Factor D (Divide total by number of participants): 201933.71
Average Length of Stay on the Waiver: 357

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation 1:1	15 minutes	73	3535.95	16.46	4248726.80	
Day Habilitation	15 minutes	171	2917.32	8.79	4384994.52	
Day Habilitation Small Group	15 minutes	58	3641.71	13.12	2771195.64	
Day Habilitation w/ meals (1:1)	1 day	81	166.83	9.77	132024.26	
Small Group Day Hab 1:6 (Remote)	15 minutes	6	364.17	6.65	14530.38	
Day Hab w/ Meals delivered by Third Party Vendor	1 day	2	268.40	6.71	3601.93	
Employment Readiness Total:						591059.85
Employment Readiness (Remote)	15 minutes	7	436.55	3.92	11978.93	
Pre-Vocational/Employment Readiness	15 minutes	35	2182.74	7.58	579080.92	
In-Home Supports Total:						44362071.44
High Intensive In-Home Supports	15 minutes	55	9968.01	10.06	5515299.93	
In-Home Supports	15 minutes	521	7950.28	9.21	38148703.05	
In-Home Supports (Remote)	15 minutes	1	1590.06	9.21	14644.45	
In-Home Supports (Acute Care Hospital Setting)	15 minutes	15	5760.00	7.91	683424.00	
Residential Habilitation Total:						19091884.78
Res Hab 4 Intensive w/ 24 hr LPN (U1 TE)	1 day	1	180.83	827.81	149692.88	
Res Hab 5-6 Intensive w/ 24 hr LPN (U2-HI)	1 day	5	365.00	701.24	1279763.00	
Resident Habilitation 4 Res - Basic (U1)	1 day	8	317.27	393.82	999578.17	
Resident Habilitation 4 Res - Enhanced (U3)	1 day	28	310.68	625.35	5439944.66	
Resident Habilitation 4 Res - Intensive (U4)	1 day	32	284.13	765.14	6956775.30	
Resident Habilitation 4 Res - Moderate (U2)	1 day	12	255.38	554.28	1698624.32	
Resident Habilitation 5-6 Res - Basic (U5)	1 day	1	365.00	420.81	153595.65	
Res Hab 5-6 Res					201571.25	

GRAND TOTAL: 408511890.45

Total Estimated Unduplicated Participants: 2023

Factor D (Divide total by number of participants): 201933.71

Average Length of Stay on the Waiver: 357

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(Enhanced - U7)	1 day	1	365.00	552.25		
Resident Habilitation 5-6 Res - Intensive (U8)	1 day	5	365.00	715.72	1306189.00	
Res Hab 5-6 Res (Moderate- U6)	1 day	5	360.70	502.44	906150.54	
Respite Total:						3034954.90
Respite - Hourly	15 minutes	140	2029.79	8.72	2477967.63	
Respite - Daily	1 day	14	62.88	632.71	556987.27	
Supported Employment Total:						3644585.60
Individual Supported Employment - Intake and Assessment Paraprofessional (Remote)	15 minutes	65	230.70	15.37	230480.84	
Individual Supported Employment - Intake and Assessment Professional (Remote)	15 minutes	4	108.00	15.37	6639.84	
Individual Supported Employment - Job Placement Paraprofessional (Remote)	15 minutes	1	1.00	8.52	8.52	
Individual Supported Employment - Job Placement Professional (Remote)	15 minutes	175	636.55	15.37	1712160.36	
Individual Supported Employment - Training & Supports Paraprofessional (Remote)	15 minutes	65	720.00	4.12	192816.00	
Individual Supported Employment - Training & Supports Professional (Remote)	15 minutes	224	240.00	15.37	826291.20	
Individual Supported Employment - Long Term Follow Along Paraprofessional (Remote)	15 minutes	38	240.00	8.52	77702.40	
Long-Term Supported Employment - Follow Along	15 minutes	52	256.09	8.52	113458.11	
Long-Term Follow Along Paraprofessional	15 minutes	1	0.50	7.81	3.90	
Supported Employment - Training & Supports Paraprofessional w/ EXT	15 minutes	28	63.74	15.37	27431.15	
Supported Employment - Training & Supports	15 minutes		12.00	15.37	2213.28	

GRAND TOTAL: 408511890.45

Total Estimated Unduplicated Participants: 2023

Factor D (Divide total by number of participants): 201933.71

Average Length of Stay on the Waiver: 357

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Professional w/ EXT		12				
Training & Supports Professional w/ EXT (Remote)	15 minutes	8	48.00	8.52	3271.68	
SE- Assessment Paraprofessional	15 minutes	1	4.00	8.82	35.28	
SE- Assessment Professional	15 minutes	1	432.00	16.35	7063.20	
SE- Placement Paraprofessional	15 minutes	4	960.00	10.31	39590.40	
SE- Placement Professional	15 minutes	17	960.00	16.29	265852.80	
SE- Training Paraprofessional	15 minutes	8	1810.20	4.98	72118.37	
SE- Training Professional	15 minutes	9	1504.87	4.98	67448.27	
Long Term Follow Along Professional (Remote)	15 minutes	0	0.00	1.00	0.00	
Personal Care Services Total:						6.95
Personal Care	15 minutes	1	1.00	6.95	6.95	
Skilled Nursing Total:						802542.61
Skilled Nursing - Visit/RN	15 minutes	1	1.00	19.51	19.51	
Skilled Nursing - Extended/RN	15 minutes	1	6350.61	19.51	123900.40	
Skilled Nursing - Initial Assessment	flat rate	1	1.00	156.08	156.08	
Skilled Nursing - Extended/LPN/LVN	15 minutes	6	7014.75	16.12	678466.62	
Assistive Technology Services Total:						193770.30
Assistive Technology-Goods	item	2	4.00	4346.80	34774.40	
Assistive Technology (Remote)	15 minutes	2	6.40	33.51	428.93	
Assistive Technology-Services	15 minutes	17	64.00	33.50	36448.00	
Assistive Technology - Ongoing	15 minutes	30	121.00	33.50	121605.00	
Assistive Technology-Ongoing (Remote)	15 minutes	1	12.10	33.60	406.56	
Assistive Technology-PERS (Installation)	item	1	1.00	66.53	66.53	

GRAND TOTAL: 408511890.45

Total Estimated Unduplicated Participants: 2023

Factor D (Divide total by number of participants): 201933.71

Average Length of Stay on the Waiver: 357

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology-PERS (Monthly)	1 month	1	1.00	40.88	40.88	
Behavioral Supports Total:						21723484.06
Behavior Support - Diagnostic Assessment	flat rate	13	4.00	376.57	19581.64	
Behavior Support - Non-professional Services	15 minutes	105	18235.20	9.44	18074730.24	
Behavior Support - Paraprofessional Services	15 minutes	50	157.29	24.85	195432.82	
Behavior Support - Professional Services	15 minutes	436	130.78	40.35	2300760.23	
Behavior Support - Diagnostic Assessment (Remote)	flat rate	5	1.60	376.57	3012.56	
Behavior Support - Non-professional Services (Remote)	15 minutes	21	3647.04	9.44	722989.21	
Behavior Support - Paraprofessional Services (Remote)	15 minutes	20	62.92	24.85	31271.24	
Behavior Support - Professional (Remote)	15 minutes	178	52.31	40.35	375706.11	
Companion Services Total:						16917887.44
Companion Services Individual	15 minutes	281	4859.19	8.11	11073656.68	
Companion Services Group	15 minutes	62	4188.72	4.62	1199816.96	
Companion 1:2	15 minutes	162	4859.19	5.90	4644413.80	
Creative Arts Therapies Total:						144795.55
Creative Arts Therapies (CAT) - Dance	45 minutes	1	1.00	32.91	32.91	
CAT -Art (Remote)	45 minutes	1	28.80	32.82	945.22	
CAT - Art	45 minutes	1	72.00	32.82	2363.04	
CAT - Art Therapy Group	45 minutes	1	1.00	32.91	32.91	
CAT - Drama	45 minutes	1	1.00	32.91	32.91	
CAT - Music Therapy Group, up to 4 PPL	45 minutes	6	72.00	32.82	14178.24	
CAT- Music Therapy w/ EXT	45 minutes	36	72.00	32.82	85069.44	

GRAND TOTAL: 408511890.45

Total Estimated Unduplicated Participants: 2023

Factor D (Divide total by number of participants): 201933.71

Average Length of Stay on the Waiver: 357

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CAT- Music Therapy w/ EXT (Remote)	45 minutes	4	87.00	32.82	11421.36	
CAT - Dance Therapy w/ EXT	45 minutes	1	72.00	32.82	2363.04	
CAT - Dance Therapy w/ EXT- Remote	45 minutes	1	14.40	32.82	472.61	
CAT - Drama Therapy w/ EXT	45 minutes	1	72.00	32.82	2363.04	
CAT - Drama Therapy w/ EXT- Remote	45 minutes	1	28.80	32.82	945.22	
CAT - Dance Therapy Group w/ EXT	45 minutes	1	72.00	32.82	2363.04	
CAT - Dance Therapy Group w/ EXT- Remote	45 minutes	1	14.40	32.82	472.61	
CAT - Drama Therapy Group w/ EXT	45 minutes	1	72.00	32.82	2363.04	
CAT - Drama Therapy Group w/ EXT- Remote	45 minutes	1	28.80	32.82	945.22	
CAT- Art Therapy w/EXT	45 minutes	1	72.00	32.82	2363.04	
CAT- Art Therapy w/EXT (Remote)	45 minutes	1	28.80	32.82	945.22	
CAT- Art Therapy Group EXT	45 minutes	1	72.00	32.82	2363.04	
CAT- Art Therapy Group EXT (Remote)	45 minutes	1	14.40	32.82	472.61	
CAT- Dance Therapy (Remote)	45 minutes	1	28.80	32.82	945.22	
CAT- Dance Therapy Group	45 minutes	1	72.00	32.82	2363.04	
CAT- Drama Therapy Remote	45 minutes	1	28.80	32.82	945.22	
CAT- Drama Therapy Group	45 minutes	1	72.00	32.82	2363.04	
CAT- Music Therapy	45 minutes	1	72.00	32.82	2363.04	
CAT- Music Therapy (Remote)	45 minutes	1	14.40	32.82	472.61	
CAT- Music Therapy Group w/EXT	45 minutes	1	72.00	32.82	2363.04	
CAT- Music Therapy Group w/ EXT (Remote)	45 minutes	1	14.40	32.82	472.61	
Dental Total:						132.73
Dental Services					132.73	

GRAND TOTAL: 408511890.45

Total Estimated Unduplicated Participants: 2023

Factor D (Divide total by number of participants): 201933.71

Average Length of Stay on the Waiver: 357

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	visit	1	1.00	132.73		
Family Training Total:						**10119.83**
Family Training - Remote	15 minutes	1	126.24	22.77	**2874.48**	
Family Training - Non-Family	15 minutes	1	1.00	20.02	**20.02**	
Family Training - Non-Family (Remote)	15 minutes	1	1.00	20.02	**20.02**	
Family Training - Professional	15 minutes	1	315.60	22.77	**7186.21**	
Family Training - Small Group Peer	15 minutes	1	1.00	11.01	**11.01**	
Family Training - Small Group Professional	15 minutes	1	1.00	8.08	**8.08**	
Health Assessment and Coordination Total:						**119709.36**
Health Assessment and Coordination Telehealth Service	monthly	314	12.00	31.77	**119709.36**	
Host Home Total:						**13483736.37**
Host Home Residential Care - Basic (UA)	1 day	35	353.07	240.43	**2971101.70**	
Host Home Residential Care - Med (UB)	1 day	22	331.30	268.90	**1959904.54**	
Host Home Residential Care - High (UC)	1 day	30	355.79	349.56	**3731098.57**	
Host Home Residential Care - High (UD)	1 day	17	358.62	790.88	**4821631.56**	
Individualized Day Supports Total:						**30123129.83**
Individualized Day Support - 1:1	15 minutes	160	4609.30	13.25	**9771716.00**	
Individualized Day Support 1:2	15 minutes	502	4335.90	9.35	**20351413.83**	
Occupational Therapy Total:						**391016.17**
Occupational Therapy	15 minutes	120	98.30	32.82	**387144.72**	
OT- Assessment Ongoing (Remote)	15 minutes	12	9.83	32.82	**3871.45**	
One-Time Transitional Services Total:						**5000.00**
One-Time Transitional Services	1 unit	1	1.00	5000.00	**5000.00**	
Parenting Supports Total:						**1212243.52**

GRAND TOTAL: 408511890.45

Total Estimated Unduplicated Participants: 2023

Factor D (Divide total by number of participants): 201933.71

Average Length of Stay on the Waiver: 357

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Parenting Support - Peer	15 minutes	6	2376.60	12.52	178530.19	
Parenting Support - Professional	15 minutes	11	3604.58	22.76	902442.65	
Parenting Support - Small Group Peer	15 minutes	1	1.00	3.24	3.24	
Parenting Support - Small Group Professional	15 minutes	1	1.00	3.24	3.24	
Parenting Support - Individual Professional (Remote)	15 minutes	4	1441.83	22.76	131264.20	
Personal Emergency Response System (PERS) Total:						0.00
PERS- Installation	flat rate	0	1.00	1.00	0.00	
PERS- Monthly Service	monthly	0	1.00	1.00	0.00	
Physical Therapy Total:						706674.99
Physical Therapy	15 minutes	176	122.34	32.82	706674.99	
Small Group Supported Employment Total:						4.00
SE Gp Job Training & Supports Professional	15 minutes	1	1.00	1.00	1.00	
SE Gp Job Training & Supports Professional (Remote)	15 minutes	1	1.00	1.00	1.00	
SE Gp Job Training & Supports Paraprofessional	15 minutes	1	1.00	1.00	1.00	
SE Gp Job Training & Supports Paraprofessional (Remote)	15 minutes	1	1.00	1.00	1.00	
Speech, Hearing and Language Services Total:						48482.98
Speech, Hearing and Language - Individual	15 minutes	0	0.00	32.82	0.00	
Speech, Hearing and Language - Small Group	15 minutes	1	1.00	16.04	16.04	
Speech, Hearing and Language Assessment	15 minutes	17	66.41	32.82	37052.80	
Speech, Hearing and Language Assessment (Remote)	15 minutes	2	6.64	32.82	435.85	
Speech, Hearing and Language Service - Individual (Remote)	15 minutes	25	13.38	32.82	10978.29	

GRAND TOTAL: 408511890.45

Total Estimated Unduplicated Participants: 2023

Factor D (Divide total by number of participants): 201933.71

Average Length of Stay on the Waiver: 357

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Living with Transportation Total:						**198658853.85**
SL (1) 1:1 AON w/TRANS (R-ON)	1 day	4	16.11	967.20	**62326.37**	
SL (1) 1:1 AON w/TRANS (R-ON) +1	1 day	4	16.11	915.42	**58989.66**	
SL (1) 1:1 AON w/TRANS (R-ON) +2	1 day	4	16.11	780.29	**50281.89**	
SL(2) Basic Support Level 1 w/TRANS (R-ON)	1 day	2	71.73	528.82	**75864.52**	
SL(2)Basic Support Level 1 w/TRANS (R-ON) +1	1 day	2	71.73	509.41	**73079.96**	
SL(2)Basic Support Level 1 w/TRANS (R-ON) +2	1 day	2	71.73	476.97	**68426.12**	
SL(2) Inten Support Level 1 w/TRANS (R-ON)	1 day	10	15.95	812.54	**129600.13**	
SL(2) Inten Support Level 1 w/TRANS (R-ON) +1	1 day	10	15.95	799.80	**127568.10**	
SL(2) Inten Support Level 1 w/TRANS (R-ON) +2	1 day	10	15.95	712.14	**113586.33**	
SL(2) Mod Support Level 1 w/TRANS (R-ON)	1 day	1	18.25	625.26	**11411.00**	
SL(2) Mod Support Level 1 w/TRANS (R-ON) +1	1 day	1	18.25	623.74	**11383.26**	
SL(2) Mod Support Level 1 w/TRANS (R-ON) +2	1 day	1	18.25	589.60	**10760.20**	
SL(3) Basic Support Level 1 w/TRANS (R-ON)	1 day	1	1.00	365.30	**365.30**	
SL(3) Basic Support Level 1 w/TRANS (R-ON) +1	1 day	1	1.00	377.41	**377.41**	
SL(3) Basic Support Level 1 w/TRANS (R-ON) +2	1 day	1	1.00	374.91	**374.91**	
SL(3) Inten Support Level 1 w/TRANS (R-ON)	1 day	3	33.23	592.52	**59068.32**	
SL(3) Inten Support Level 1 w/TRANS (R-ON) +1	1 day	3	33.23	611.01	**60911.59**	
SL(3) Inten Support Level 1 w/TRANS (R-ON) +2	1 day	3	33.23	585.82	**58400.40**	
SL (3) Moderate Support Level 1 W/TRANS (R-ON)	1 day	1	168.00	546.24	**91768.32**	

GRAND TOTAL: 408511890.45

Total Estimated Unduplicated Participants: 2023

Factor D (Divide total by number of participants): 201933.71

Average Length of Stay on the Waiver: 357

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
SL (3) Moderate Support Level 1 W/TRANS (R-ON) + 1	1 day	1	168.00	567.36	95316.48	
SL (3) Moderate Support Level 1 W/TRANS (R-ON) + 2	1 day	1	168.00	556.68	93522.24	
SL 1 Res (Asleep ON) w/TRANS (UD-HI)	1 day	3	251.93	1152.41	870979.95	
SL 1 Res (AON) w/TRANS (UC-HI)	1 day	74	322.23	1152.41	27479239.50	
SL 1 Res (Periodic) w/ TRANS (U1 - HI)	15 minutes	61	11054.44	10.60	7147800.90	
SL 2 Res (Basic 1) w/ TRANS (U7 - HI)	1 day	5	286.92	606.71	870386.17	
SL 2 Res (Basic 2) w/ TRANS (U8 - HI)	1 day	170	336.78	607.06	34755763.36	
SL 2 Res (Moderate 1) w/ Transportation (U9 - HI)	1 day	2	365.00	702.44	512781.20	
SL 2 Res (Intensive 1) w/ Transportation (UB - HI)	1 day	221	318.91	891.48	62830716.98	
SL 2 Res (Moderate 2) w/ Transportation (UA - HI)	1 day	29	313.27	779.29	7079717.17	
SL 3 Intensive w/ LPN w/ Transportation (TE - HI)	1 day	12	332.07	684.63	2728141.01	
SL 3 Res (Basic 1) w/ Transportation (U1- HI)	1 day	2	310.33	444.65	275976.47	
SL 3 Res (Basic 2) w/ Transportation (U2 - HI)	1 day	11	365.00	444.65	1785269.75	
SL 3 Res (Intensive 1) w/ Transportation (U5 - HI)	1 day	31	332.28	634.16	6532279.23	
Supported Living 3 Res (Intensive 2) w/ Transportation (U6 - HI)	1 day	161	346.75	728.92	40693234.61	
Supported Living 3 Res (Moderate 2) w/ Transportation (U4 - HI)	1 day	21	282.49	587.88	3487474.65	
Res - Moderate 1 w/ Transportation (U3 HI)	1 day	1	336.00	587.88	197527.68	
SL Periodic with transportation (Remote)	15 minutes	9	1658.10	10.60	158182.74	
Supported Living Total:						37689620.37
SL (1) One to One Awake Overnight (R-ON)	1 day	2	9.42	18.32	345.15	

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Average Length of Stay on the Waiver: 357

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
SL (1) One to One Awake Overnight (R-ON) +1	1 day	2	9.42	18.32	345.15	
SL (1) One to One Awake Overnight (R-ON) +2	1 day	2	9.42	18.32	345.15	
SL (2) Basic Support Level 1 (R-ON)	1 day	1	27.47	411.52	11304.45	
SL (2) Basic Support Level 1 (R-ON) +1	1 day	1	27.47	392.11	10771.26	
SL (2) Basic Support Level 1 (R-ON) +2	1 day	1	27.47	359.67	9880.13	
SL (2) Inten Support Level 1 (R-ON)	1 day	1	15.52	695.24	10790.12	
SL (2) Inten Support Level 1 (R-ON) +1	1 day	1	15.52	682.50	10592.40	
SL (2) Inten Support Level 1 (R-ON) +2	1 day	1	15.52	594.84	9231.92	
SL (2) Mod Support Level 1 (R-ON)	1 day	1	18.24	507.96	9265.19	
SL (2) Mod Support Level 1 (R-ON) +1	1 day	1	18.24	506.44	9237.47	
SL (2) Mod Support Level 1 (R-ON) +2	1 day	1	18.24	472.31	8614.93	
SL (3) Basic Support Level 1 (R-ON)	1 day	1	14.14	314.01	4440.10	
SL (3) Basic Support Level 1 (R-ON) +1	1 day	1	14.14	328.10	4639.33	
SL (3) Basic Support Level 1 (R-ON) +2	1 day	1	14.14	325.19	4598.19	
SL (3) Intens Support Level 1 (R-ON)	1 day	3	33.72	503.52	50936.08	
SL (3) Intens Support Level 1 (R-ON) + 1	1 day	3	33.72	522.02	52807.54	
SL (3) Intens Support Level 1 (R-ON) + 2	1 day	3	33.72	496.82	50258.31	
SL (3) Moderate Support Level (1) (R-ON)	1 day	1	168.00	457.24	76816.32	
SL (3) Moderate Support Level (1) (R-ON) + 1	1 day	1	168.00	478.37	80366.16	
SL (3) Moderate Support Level (1) (R-ON) + 2	1 day	1	168.00	467.69	78571.92	
SL Periodic	15 minutes	0	0.00	9.78	0.00	
SL 1 Res (Asleep ON-					629172.05	

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Average Length of Stay on the Waiver: 357

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
UD)	1 day	2	331.07	950.21		
SL 1 Res (Awake ON-UC)	1 day	41	188.33	950.21	7337075.02	
SL 1 Res (Periodic- U1)	15 minutes	37	2423.77	9.78	877065.41	
SL 2 Res (Basic 1-U7)	1 day	2	137.37	489.42	134463.25	
SL 2 Res Basic 2- U8)	1 day	41	316.76	489.77	6360721.35	
SL 2 Res (Intensive 1-UB)	1 day	28	310.43	774.18	6729203.53	
SL 2 Res (Moderate 1-U9)	1 day	3	364.77	585.15	640335.50	
SL 2 Res (Moderate 2-UA)	1 day	6	365.00	662.00	1449780.00	
SL 3 Intensive w/ LPN (U1-TE)	1 day	2	110.00	684.63	150618.60	
SL 3 Res (Basic 1- U1)	1 day	3	141.43	355.66	150902.98	
SL 3 Res (Basic 2- U2)	1 day	5	218.49	355.66	388540.77	
SL 3 Res (Intensive 1-U5)	1 day	30	337.15	545.17	5514121.96	
SL Res (Intensive 2-U6)	1 day	29	316.98	639.93	5882505.33	
SL 3 Res (Moderate 1-U3)	1 day	1	336.00	498.89	167627.04	
SL 3 Res (Moderate 2-U4)	1 day	1	28.00	498.89	13968.92	
SL Periodic (Remote)	15 minutes	8	1939.02	5.54	85937.37	
SL (Acute Care Hospital Setting)	15 minutes	15	5760.00	7.91	683424.00	
Wellness Services Total:						3935229.40
Wellness Services - Fitness Trainer Individual	15 minutes	527	194.41	24.60	2520370.12	
Wellness Services - Fitness Trainer Group	15 minutes	1	208.00	14.76	3070.08	
Wellness Services - Bereavement Counseling	15 minutes	5	400.00	21.33	42660.00	
Wellness Services - Healthy Relationships	15 minutes	10	196.97	25.44	50109.17	
Wellness Services -					1065804.34	

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Average Length of Stay on the Waiver: 357

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nutritional Counseling	15 minutes	572	85.59	21.77		
Wellness Services - Fitness Trainer Individual (Remote)	15 minutes	105	38.88	24.60	100427.04	
Wellness Services - Fitness Trainer Group (Remote)	15 minutes	1	41.60	14.76	614.02	
Wellness Services - Bereavement Counseling (Remote)	15 minutes	1	80.00	21.33	1706.40	
Wellness Services - Healthy Relationships (Remote)	15 minutes	2	39.39	25.44	2004.16	
Wellness Services - Nutritional Counseling (Remote)	15 minutes	114	17.12	21.77	42488.07	
Wellness Services- Massage Therapy	15 minutes	25	208.00	20.38	105976.00	

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