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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Individual and Family Support (IFS) Waiver

C. Waiver Number:DC.1766

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
10/01/22

Approved Effective Date of Waiver being Amended: 11/01/20

2. Purpose(s) of Amendment

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

The amendment application for the IFS Waiver contains changes to be effective October 1, 2022, as follows:

SERVICE CHANGES:

-Modifies assistive technology services by adding additional allowable assistive technology items to include: virtual assistants/smart speakers, environmental controls devices, applications for prompting, and guidance and navigation. Modifies the requirement for an Assistive Technology assessment to include assistive technology that costs under $1,000, no longer requires an assessment. DDS Service Provider can acquire assistive technology based on the individual's IDT/Support team justification of need in the individual's support plan. Assistive technology that costs over $1,000 must include assistive technology assessment conducted by a professional of: occupational therapy; physical therapy; speech, hearing, and language services; assistive technology professional (RESNA Certified); Certified Enabling Technology Integration Specialist (ETIS) employed by a SHIFT accredited waiver service provider; or another comparable national accreditation body, as approved by DDS.

-Adds the option for participant-directed services, which means that participants, or their representatives if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The PDS delivery model is an alternative to traditionally delivered and managed services, such as an agency delivery model. Participant-direction of services allows participants to have the responsibility for managing all aspects of service delivery in a person-centered planning process. The PDS delivery option will be offered for the following services: in-home supports service, individualized day supports services, companion services, respite daily services, and individual-directed goods and services.

-Adds a new service, Individual-directed goods and services, which are services, equipment, or supplies not otherwise provided through the IFS Waiver or State Plan. Furthermore, IDGS are only available if the individual does not otherwise have the funds to purchase the good or service or the good or service is not available through another source. IDGS are purchased from the participant-directed budget. Experimental or prohibited treatments are excluded. These goods and services must address an identified need in the participant's individual service plan (ISP). IDGS are only available to waiver participants who are enrolled in the participant-directed services program.

-Adds remote supports services, which will enable individuals to be more independent and less reliant on staff to be physically present to receive support. The remote supports service will be available for the following waiver services: assistive technology services, behavioral supports, bereavement counseling, creative art therapies, day habilitation, employment readiness, family training services, fitness training, nutrition evaluation/consultation services, occupational therapy, parenting supports, sexuality education, speech, hearing, and language, and supported employment. Remote support services will be a separate billable service with a specialized rate different from the in-person service delivery rate. Remote support service rates for speech, hearing, language services, occupational therapy services, bereavement counseling, fitness training services, nutrition evaluation/consultation services, sexuality education services, and creative art therapies services will maintain the same rates.

-Modifies the scope of companion services to allow the service to be rendered by the individual's relative when participant-directed.

SYSTEMIC CHANGES:
Appendix B: Proposing four changes:

-Clarifies roles and responsibilities of Health Insurance Analysts and Medicaid Waiver Specialists in completing and submitting the Medicaid recertification form to the Department of Human Services, Economic Security Administration at least sixty (60) days prior to the expiration of the person's Medicaid eligibility period.

-Modifies who is eligible to receive waiver services by expanding IFS Waiver services to individuals with DD without a diagnosis of an Intellectual Disability (ID). The proposed DD eligibility expansion also incorporates modifications to the definitions of DD and ID and amends the waiver eligibility criteria to acknowledge that onset of ID can occur after age eighteen (18) up to age twenty-two (22). Whereas criteria before required onset of ID prior to age eighteen (18).

-Modifies the waiver enrollment process. The proposed modification will base enrollment into the IFS waiver on the individuals' identified needs. The Interdisciplinary Team will discuss services based on the individuals' specified need(s) and the most appropriate waiver will be explored.

-Modifies the reserved capacity for CFSA to DDS and ICF/IDD reserved slots. The District will decrease the reserve capacity from 15 to 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. The District will decrease reserve capacity from five (5) to up to three (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.

-Adds COVID-19 vaccination requirements for direct care staff to align with DC Health requirements.

-Adds a vendor for Financial Management Services (FMS)/Support Broker entity to provide financial management and information and assistance services for participants in the PDS program.

REIMBURSEMENT CHANGES:
- Adds a supplemental payment for waiver services. The District will be paying supplemental payments to DSPs starting FY2023 and as necessary annually to alleviate the workforce shortage. To the extent authorized by District legislation and approved under the District's Section 9817
American Rescue Plan Act Spending Plan.

-Adds rate-setting methodology for participant-directed services. The rate-setting methodology used for Medicaid services delivered through traditional agency-based model will remain the same for services that are participant-directed. Participants who elect to use PDS will determine hourly rate paid to their participant-directed workers within range set by DHCF, which falls between District's established living wage and the rate paid to PCAs delivering Waiver services through the agency-based model. The Vendor Fiscal/Employer Agent Financial Management Services (VF/EA FMS) - Support Broker entity will assist participants who elect to use PDS through provision of financial management and support broker services and will receive a PMPM payment for provision of these services.

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**	A-1
☐ **Appendix B Participant Access and Eligibility**	
☒ **Appendix C Participant Services**	C-1; C-3; C-5
☐ **Appendix D Participant Centered Service Planning and Delivery**	
☒ **Appendix E Participant Direction of Services**	
☐ **Appendix F Participant Rights**	

Component of the Approved Waiver	Subsection(s)
☒ 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 §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*):

Individual and Family Support (IFS) Waiver

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**

Draft ID: **DC.023.00.01**

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 11/01/20
Approved Effective Date of Waiver being Amended: 11/01/20

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 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 § 7-761.05(1)(a) requires DDS to [p]rovide services and supports to people in accordance with Chapter 13 of Title 7, which is the codification of D.C. Law 2-137, the "Citizens with Intellectual Disabilities Constitutional Rights and Dignity Act of 1978, effective March 3, 1979, D.C. Official Code § 7-1301.01 et seq., as amended. Under D.C. Law 2-137, DDS provides services and supports to District residents with intellectual disabilities by application to DDS and through the admission and commitment process by petition to the Family Court for licensed residential services. See D.C. Official Code § 7-1301.03(2) and 71301.03 through 7-1303.06. In addition, eligibility for services is limited to people with an intellectual disability which, when establishing qualifying intelligence quotient (IQ), includes consideration of the standard error of measurement associated with the particular IQ test, and requires adaptive deficits across at least two of the following three domains: conceptual, practical, and social.

1. Request Information (3 of 3)

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

Select one:

- (●) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

- [ ] **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- [ ] **Waiver(s) authorized under §1915(b) of the Act.**

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

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

  - [ ] **§1915(b)(1) (mandated enrollment to managed care)**
  - [ ] **§1915(b)(2) (central broker)**
  - [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
  - [ ] **§1915(b)(4) (selective contracting/limit number of providers)**
- [ ] **A program operated under §1932(a) of the Act.**

  Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:
- [ ] **A program authorized under §1915(i) of the Act.**
- [ ] **A program authorized under §1915(j) of the Act.**
- [ ] **A program authorized under §1115 of the Act.**

  Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

- [x] **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 Individual and Family Support (IFS) Waiver establishes a program to allow District residents with intellectual and developmental disabilities who live in an independent environment, either in their own home or with family or friends, to receive HCB services and supports tailored to their specific needs. The IFS Waiver meets the needs of persons who can leverage supports from family or friends and do not need residential services. In this way, the IFS Waiver will offer person-centered services that meet each person's needs in the least restrictive setting needed, applying the highest standards of quality and national best practices.

The IFS Waiver offers a full range of health and clinical services necessary to help persons with complex support needs and their families choose an alternative to institutional service that promotes community inclusion and independence by enhancing and not replacing existing informal networks. The IFS Waiver offers 20 services.

The IFS waiver has a $75,000 per person per ISP/Plan of Care year aggregate spending cap.

Goals:
The waiver aims to enable persons who live in their own homes or with family/friends to:
- lead healthy, independent, and productive lives;
- live, work, and fully participate in their communities to the fullest extent possible;
- fully exercise their rights as District residents; and
- promote the integrity and well-being of their families.

Furthermore, the IFS 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:
- Ensure sufficient alternatives and supports that will enable people to live with the least amount of paid support while promoting independence for persons through the provision of services meeting the highest standards of quality and national best practices;
- All people have an opportunity to acquire essential skills and receive the supports necessary to enter the workforce and pursue careers of their choosing;
- All people have access to the necessary services and supports that will enable aging in the least restrictive setting possible;
- 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;
- Provision of person-centered services while ensuring health and safety through a comprehensive system of safeguards;
- 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
- Persons 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 District's Single State Medicaid Agency. DHCF's responsibilities include the administration of the Medicaid program, including 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. DDS/ Developmental Disabilities Administration (DDA) is the operating agency for all services provided to persons with IDD. The two agencies have an MOU to assure coordination, cooperation, and collaboration in performing their respective duties in the provision of IFS Waiver services.

Service Delivery Methods:
DDA provides each person with service coordination, as an administrative function. This LOC determination, development of the ISP, support to access all necessary services and supports, crisis intervention support, and monitoring of the delivery of services/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 LON 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.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.

All IFS waiver participants are afforded the opportunity to self-direct the following services: individual-directd goods and services (IDGS), in-home supports, companion, and individualized day supports (IDS). Waiver participants who choose to self-direct these services have choice and control over how they are provided and by whom. To assist participants choosing to self-

direct these services, a District-wide, IRS-approved Vendor Fiscal/Employer Agent FMS-Support Broker entity provides financial management services (FMS) and information and assistance (I&A) supports as administrative activities. The service coordinator is also responsible for re-introducing the participant-directed services program to each beneficiary not currently enrolled in the program at the beneficiary's annual renewal and must document that the participant-directed services option was discussed with the beneficiary at that time.

3. Components of the Waiver Request

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

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §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 §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 §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee

schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

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

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

7. Contact Person(s)

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

Last Name:

Katherine

First Name:

Rogers

Title:

Director, Long Term Care Administration

Agency:

Department of Health Care Finance

Address:

441 4th Street NW

Address 2:

Suite 900

City: Washington

State: **Dist. of Columbia**

Zip: 20001

Phone: Ext: ☐ TTY

Fax:

E-mail:

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: 250 E Street, SW

Address 2:

City: Washington

State: **Dist. of Columbia**

Zip: 20024

Phone: (202) 730-1618 Ext: ☐ TTY

Fax: (202) 590-7618

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 §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section

VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Dist. of Columbia**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

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:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

   ○ **The waiver is operated by the state Medicaid agency.**

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (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 IFS 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 Waiver MOA. DHCF, in its Administrative Authority role, retains ultimate authority and oversight for the IFS Waiver and accepts complete responsibility for the entire IFS 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 IFS 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 that is concerned with the overall operation of the waiver with particular interest in whether quality and performance measures are being met.

In addition there is a DDS/DDA Quality Committee. This DDS/DDA Quality Committee is responsible for advising DHCF on the challenges that IFS 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 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.

In addition, DHCF hosts a quarterly DHCF-DDS/DDA Quality Management Committee designed just for Waiver services. This DHCF- DDS/DDA Quality Management Committee is responsible for advising DHCF on the challenges that IFS waiver participants face (including their satisfaction with the waiver services being provided) and seeks to find solutions to improve service delivery.

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.

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 Contracting 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.*

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 evaluation	☒	☒	☐
Review of Participant service plans	☒	☒	☐
Prior authorization of waiver services	☒	☒	☒
Utilization management	☒	☒	☐
Qualified provider enrollment	☒	☒	☐
Execution of Medicaid provider agreements	☒	☐	☐
Establishment of a statewide rate methodology	☒	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Quality assurance and quality improvement activities	☒	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
AA.a.1.a.PM.1. Percentage of provides that me oversight compliance Agreements.
N=Number of providers that met oversight compliance/D= Number of providers reviewed

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:
	☐ **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.

b. Methods for Remediation/Fixing Individual Problems

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

Remediating and fixing individual/systemic problems are the shared responsibility of the State Agency's Long Term Care Division and the Division of Quality and Health Outcomes. 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 weekly 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 reevaluation 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: PCR	☒ **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 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 SubGroup	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:

The DDS Establishment Act at D.C. Official Code § 7-761.05(1)(a) (2018 Repl.), as amended, which permits services in accordance with D.C. Law 2-137, codified at D.C. Official Code §7-1301.01 et seq. (2018 Repl.).

Eligibility is expanded to include people with developmental disabilities without a diagnosis of an Intellectual Disability (ID) who have three substantial deficits in major life functions, as assessed by the existing level of need (LON) assessment.

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. In addition, eligibility for services is limited to people with an intellectual disability which, when establishing a qualifying intelligence quotient (IQ), includes consideration of the standard error of measurement associated with the particular IQ test, and requires adaptive deficits across at least two of the following three domains: conceptual, practical, and social.

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:
(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.

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 is established based on projected costs and estimated utilization of HCBS services persons likely to enroll in the IFS waiver. The IFS waiver has 18 of the HCBS services that exist in the District's IDD waiver. To develop the annual cost limit, the District modeled projected costs and estimated utilization of persons enrolled in the IDD waiver with similar need profiles (requisite level of natural supports; no utilization of residential services) to those the District believes are likely to enroll in the IFS waiver. The District analysed utilization across those 18 HCBS services, then included additional costs for the new Education Support service. In its final projections, the District determined that estimated average utilization of those persons for the services included in the IFS waiver would be below the proposed $75,000 annual cap for all five waiver years.

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

◉ **The following dollar amount:**

Specify dollar amount: 75000

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)

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:

Prior to applying to the Individual and Family Support Waiver, each applicant will be assessed for their level of service need with consideration of available natural and community supports to determine if services offered under this waiver will support his or her health and safety needs. In addition, the service coordinator will facilitate development of the Individual Service Plan (ISP) identifying the applicant's needs, goals, and preferences as well as other supports available under other programs such as the Medicaid State Plan, as further specified in Appendix D. The ISP will demonstrate for the DDA which waiver services, under DDS's available waiver programs, will be most appropriate and meet the participant's needs, goals, and desires.

If the ISP exceeds the individual cost neutrality cap for this waiver, the service coordinator will explore with the applicant, and his or her legal representative and family members, ways to modify the proposed waiver services while maintaining the applicant's health and safety. For example, this may entail arranging for more informal supports and reducing personal supports provided, however, if the health and safety of the applicant will not be compromised and the ISP is acceptable to the applicant and his or her legal representative and family members. DDS will not approve the final ISP if it is determined that reducing services would have a detrimental impact on the applicant's health and safety. If the assessed needs cannot be supported by this waiver or the ISP's proposed services exceed the cost limit for this waiver, the applicant will be denied enrollment into the Individual and Family Supports Waiver and given the opportunity to request a Fair Hearing as further specified in Appendix F. DDS will refer the applicant to another waiver with a higher cost limit, if available. If another program option is not available at that time, the applicant will retain his or her position on the DDS Waiting List until an opportunity is available.

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	30
Year 2	60
Year 3	90
Year 4	120
Year 5	150

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	
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 ICF/IDD	
Transition from CFSA to DDS	

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):*

Effective October 1,2022
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	5
Year 2	5
Year 3	3
Year 4	3
Year 5	3

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):*

Effective October 1, 2022
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/IDD 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	15
Year 2	15
Year 3	10
Year 4	10
Year 5	10

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.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

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

- (●) **No**
- ( ) **Yes**

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

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

- [ ] **Low income families with children as provided in §1931 of the Act**
- [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 §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**

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

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

Specify:

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

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

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

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

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

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

☒ **Aged and disabled individuals who have income at:**

Select one:

◉ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

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

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

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

◉ **The following standard included under the state plan**

Select one:

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**

(*select one*):

- ◉ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

- ○ **A dollar amount which is less than 300%.**

Specify dollar amount:

- ○ **A percentage of the Federal poverty level**

Specify percentage:

- ○ **Other standard included under the state Plan**

Specify:

- ○ **The following dollar amount**

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

- ○ **The following formula is used to determine the needs allowance:**

Specify:

- ○ **Other**

Specify:

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

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

Specify:

Specify the amount of the allowance (*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:

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

- ◉ **Not Applicable (see instructions)**
- ○ **AFDC need standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

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

  Specify:
- ○ **Other**

  Specify:

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

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

Select one:

- ◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ○ **The state does not establish reasonable limits.**
- ○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:

- ○ **The following dollar amount:**

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

- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:

- ○ **Other**

  Specify:

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

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

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

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

Select one:

- (●) **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The state does not establish reasonable limits.**
- ( ) **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

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:

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

- ○ **Directly by the Medicaid agency**
- ◉ **By the operating agency specified in Appendix A**
- ○ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- ○ **Other**

Specify:

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), is someone who oversees the initial habilitative assessment of a person; develops, monitors, and reviews ISPs; and integrates and coordinates Waiver services.

The QIDP shall have at least one (1) of the following qualifications:
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;
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;
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;
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;
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;
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;
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
viii. A registered nurse with specialized training in intellectual disabilities or with one (1) year of experience in working with persons with intellectual 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.

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:

(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.

The D.C. Official Code to define Developmental Disability is currently being updated and reviewed to be implemented as law.

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. In addition, eligibility for services is limited to people with an intellectual disability which, when establishing a qualifying intelligence quotient (IQ), includes consideration of the standard error of measurement associated with the particular IQ test, and requires adaptive deficits across at least two of the following three domains: conceptual, practical, and social.

A person shall meet the LOC determination if:

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

b) The person's primary disability is an intellectual or a developmental disability and the person has an ongoing need for support across multiple environments (e.g. home, school, work or community) as evidenced by substantial functional limitations in at least three of the following major life activities:

(1) Self-care;

(2) Understanding and use of language;

(3) Functional academics;

(4) Social skills;

(5) Mobility;

(6) Self-direction;

(7) Capacity for independent living;

(8) Health and safety; or

(9) Behavior challenges.

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:

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 an 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 IFS 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 IFS 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 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 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 Level of Care re-determination processes by the individual's support team for persons enrolled in the IFS 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 individuals during the planning process. The DDA service coordinator will also provide individuals 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.

When applicable, the DDA Health Insurance Analyst or the Medicaid Waiver Specialist completes the Medicaid recertification form and submits it to the Economic Security Administration (ESA) at least 60 days prior to the expiration of the person's Medicaid eligibility period. 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 revicew has been completed.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

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

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

Performance Measure:
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):
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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **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**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: N/A	☐ **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):*
	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:

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.

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. The DDA Waiver Unit will ensure the financial eligibility for enrollment to waiver and service authorization. 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 90% (10% margin of error) 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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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 I/DD 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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **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 both this waiver and the Individuals with Developmental Disabilities (IDD) waiver and all available services offered under those waivers, and are provided the link to the DDS website identifying 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 to receive remote supports services and/or in-person services.

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 IFS 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	Education Supports		
Statutory Service	Employment Readiness		
Statutory Service	Group Supported Employment		
Statutory Service	Respite		
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	In-Home Supports		
Other Service	Individual Directed Goods and Services		
Other Service	Individual Supported Employment		
Other Service	Individualized Day Supports		
Other Service	Occupational Therapy		
Other Service	Parenting Supports		
Other Service	Personal Emergency Response System (PERS)		
Other Service	Physical Therapy		
Other Service	Speech, Hearing, and Language		
Other Service	Unpaid Family/Caregiver Training		
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:

Habilitation

Alternate Service Title (if any):

Day Habilitation

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04020 day habilitation

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

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

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 settings. 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), 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 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 be comprised 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.
Services may be offered in a large group or a small group setting.

Services may be provided via remote support. Remote Supports is an electronic method of service delivery that enables a person to be more independent and less reliant on staff to be physically present to receive support. The remote caregiver can interact, coordinate supports, monitor, and/or respond to the person's needs through equipment capable of live two-way communication.
Services may be provided via remote support. Remote Supports is an electronic method of service delivery that enables a person to be more independent and less reliant on staff to be physically present to receive support. The remote caregiver can interact, coordinate supports, monitor, and/or respond to the person's needs through equipment capable of live two-way communication.

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

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

1) People 64 years and younger w/ a Level of Need Day Composite score of 2 or less would not be eligible to attend Day Hab services, 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 64 years and younger w/ a Level of Need Day 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.

(3) Day Hab services may not be authorized for any person for more than 24 hour per week. Wrap around services are available, including Supported Employment, Ind Day Supports, Empl Rd and Companion in combination for up to 40 hours per week. This limit is not applicable to Sm Group Day Hab services.

Any person with a Level of Need Day Composite score of 1 or 2 is not eligible for Day Hab services. The person should be offered employment services, either through the waiver, the Rehabilitation Services Administration, or other community based options.

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 of 50, inclusive of people who receive support through the IFS 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 with a daily census under, may only receive authorizations for services for new persons up to a daily census of 50 in the setting. The daily census is inclusive of people who receive support through the IFS 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.

(2) Current non-sm group Day Hab settings with a daily census of 50 people or more in the setting will not be eligible for authorizations for services for new persons until their daily census is less than 50 people in the setting. The daily census is inclusive of people who receive support through the IFS 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 in the number of facility-based settings—only community-based programs for currently enrolled providers. No facility-based settings permitted for newly enrolling providers, except for Small Group Day Habilitation providers.

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 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**

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.
Certified Enabling Technology Integration Specialist (ETIS) employed by a SHIFT Accredited DDS Service Provider or Enabling Technology Credential (ETC)

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 person's 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 maximum staffing ratio of 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 which 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 who are Deaf or Hard of Hearing 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:

Education

Alternate Service Title (if any):

Education Supports

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04030 education services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Education Supports consists of education and related services, as defined in Sections (22) and (25) of the Individuals with Disabilities Education Act (IDEA), to the extent that they are not available under a program funded by IDEA or available for funding by the Rehabilitation Services Administration (RSA).

Education Supports is intended for a person who has:
• A demonstrated need for education supports services to enhance or maintain independence; to increase, maintain, or improve education; and/or to support increased community inclusion; or
• An employment outcome-related goal for skill attainment or development that is documented in a service plan related to the need for education supports services, and which are not available through vocational rehabilitation funding.

Education Supports is limited to payment for the following:
• Classes (one communication education professional and one participant or a group of no more than four learners taught collectively by a communication education professional) to teach participants who are deaf American Sign Language, Visual Gestural Communication, or another form of communication. To receive this type of education, participants must be age 21 and older or under 21 years of age with a high school diploma. The participant must also have been assessed as benefitting from learning American Sign Language or another form of communication.

Exclusions -
The following items are excluded from coverage under Education Supports (please note this is not an exhaustive list of excluded items):

•• Room and board.
•• Payments for books.
•• Payment for recreational classes, activities and programs offered through recreational commissions, townships, boroughs, etc.
•• Tuition for adult education classes offered by online universities.
•• Tuition for online classes.
•• Tuition for adult education classes provided on disability specific campuses.

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

The provision of Education Support services may not be provided on the same day at the same time as the direct provision of any of the following: Supported Employment; Day Habilitation; and Individual Day Support.

This service may be used in combination with any other waiver day or vocational support service for a total of no more than forty hours per week. This includes Employment Readiness.
Education Support services may be offered individually (1:1) or in small group (1:3 or 1:4).

This service can be delivered in Washington DC, Maryland, and/or Virginia and within a twenty-five mile radius of the District.

Participants can receive a maximum of:
- $5,000 per semester of communications education for participants taking at least 6 credit hours of classes per semester.

This service may be used in combination with any other waiver day or vocational support service, for a total of no more than 40 hours per week. This includes Day Habilitation, Employment Readiness (Empl Rd), Small (Sm) Group Supported Employment, and Individualized (Ind) Day Supports.

For coverage of Education Support Services that are also provided by RSA to be authorized under the IFS waiver, an application and denial for RSA-funded education services is required.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Education Program; Institution of Postsecondary Education
Agency	Communication Education Agency
Individual	Communication Education Professional

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Education Supports

Provider Category:
Agency
Provider Type:

Adult Education Program; Institution of Postsecondary Education

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Institution of Postsecondary Education: Must be an accredited postsecondary institution or program by the United States Department of Education.

Other Standard *(specify):*

Adult Education Program:
1. Have a waiver service location in Maryland, Washington DC, or Virginia.
2. Have a signed DDS Provider Agreement on file with DDS.
3. Have at least one staff person with a four year degree and state teaching credentials.
4. Comply with Department standards related to provider qualifications.

Staff working for or contracted with the adult education program as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.
2. Have criminal history clearances

Institution of Postsecondary Education:
1. Have a waiver service location in Maryland, Washington DC, or Virginia.
2. Have a signed DDS Provider Agreement on file with DDS.
3. Comply with Department standards related to provider qualifications.

Staff providing on campus peer support as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
1. Be at least 18 years of age.
2. Have criminal history clearances.

Verification of Provider Qualifications

Entity Responsible for Verification:

AWC FMS, VF/EA FMS, DDS or its Designee

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by DDS. New providers may be qualified more frequently depending on which monitoring cycle they are assigned to.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Education Supports

Provider Category:

Agency

Provider Type:

Communication Education Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Have, at a minimum, Qualified Level Certification from the American Sign Language Teachers Association (ASLTA).

Other Standard *(specify):*

To teach communication to participants who are deaf, the Communication Education Agency must meet the following standards:
1. Have a waiver service location in Washington DC, Virginia or Maryland.
2. Have a signed DDS Provider Agreement on file with DDS.
3. Complete standard DDS required orientation and training.
4. New providers demonstrate compliance with DDS standards through completion of a self-assessment and validation of required documentation, policies and procedures.
5. Comply with Department standards related to provider qualifications.

Communication Education Professionals working for or contracted with the agency as well as volunteers utilized in providing this service if they will spend any time alone with a participant must meet the following standards:
6. Be at least 18 years of age.
7. Have at least advanced or higher Sign Language Skills as determined by the Sign Language Proficiency Interview (SLPI).
8. Have criminal history clearances

Verification of Provider Qualifications

Entity Responsible for Verification:

AWC FMS, VF/EA FMS, DDS or its Designee

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by DDS. New providers may be qualified more frequently depending on which monitoring cycle they are assigned to.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Education Supports

Provider Category:

Individual

Provider Type:

Communication Education Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Have, at a minimum, Qualified Level Certification from the American Sign Language Teachers Association (ASLTA).

Other Standard *(specify):*

1. Be at least 18 years of age.

2. Have a waiver service location in Maryland, Washington DC, or Virginia.
3. Have a signed DDS Provider Agreement on file with DDS.

4. Complete standard DDS required orientation and training.
5. New providers demonstrate compliance with DDS standards through completion of a self-assessment and validation of required documentation, policies and procedures.
6. Comply with Department standards related to provider qualifications.
7. Have at least advanced or higher Sign Language Skills as determined by the Sign Language Proficiency Interview (SLPI).
8. Have criminal history clearances.

Verification of Provider Qualifications

Entity Responsible for Verification:

AWC FMS, VF/EA FMS, DDS or its Designee

Frequency of Verification:

At least once during a 3-year monitoring cycle and more frequently when deemed necessary by DDS. New providers may be qualified more frequently depending on which monitoring cycle they are assigned to.

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:**

Service Definition *(Scope):*

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

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 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 in the number of facility-based settings employment readiness services settings shall be allowed. Current providers shall 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.

A person 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.

Services may be provided via remote support. Remote Supports is an electronic method of service delivery that enables a person to be more independent and less reliant on staff to be physically present to receive support. The remote caregiver can interact, coordinate supports, monitor, and/or respond to the person's needs through equipment capable of live two-way communication.

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.
All new Employment Readiness settings must be fully compliant with the requirements of the HCBS SettingsRule.

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 persons up to a daily census of fifty (50) people in the setting. The daily census is inclusive of people who receive support through the IFS 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 fifty (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.

For people who are currently enrolled in Employment Readiness services, the service may only be reauthorized for up to one year from the person's next ISP date, 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.

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.)

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 persons enrolled in the IFS waiver, this benefit is only used by persons in the IFS waiver to reach the employment readiness 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 nonemergency medical transportation broker. The service must be reserved in advance, and trips often include other non-IFS 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 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 in the number of facility-based settings shall be allowed. Current providers of employment readiness services shall be prohibited from increasing the number of facility-based settings at which services are provided; and newly enrolling provider 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 services for employment readiness. Employment Readiness 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**

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 Accredited DDS Service Provider or Enabling Technology Credential (ETC)

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; and within one year of the effective date of the waiver renewal for current 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 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;; and COVID vaccination consistent with DC Health requirements
• 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, 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 possess 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:

Supported Employment

Alternate Service Title (if any):

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):*

Group Supported Employment 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. 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. 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, group employment supports, and supported employment individual employment support services.

Services may be provided via remote support. Remote Supports is an electronic method of service delivery that enables a person to be more independent and less reliant on staff to be physically present to receive support. The remote caregiver can interact, coordinate supports, monitor, and/or respond to the person's needs through equipment capable of live two-way communication.

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 Group Supported Employment.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: 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 SHIFT Accredited DDS Service Provider or Enabling Technology Credential (ETC).

Other Standard *(specify):*

Provider enrolled to provide services through DDS/DHCF and has current Medicaid agreement.
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 is free from communicable diseases as confirmed by an annual purified protein as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test; and COVID vaccination consistent with DC Health requirements.
- 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 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, 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:

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 is only provided to persons served through the waiver who live in their own homes, or their family homes.
Respite may not be offered in an ICF.

Respite care will ensure that persons served through the waiver have access to community activities as delineated in the person's ISP/Plan of Care.

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. Hourly respite care is 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 Plan of Care. 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 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).

Respite daily can be participant-directed or provider-managed.

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

Respite services are provided on a short-term basis. 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**

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 current Medicaid Provider 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; and COVID vaccination consistent with DC Health requirements.
• 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 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
The participant or authorized representative if designated as the common law employer of PDWs, and the VF/EA FMS-Support Broker entity determining if PDW has met minimum qualifications.

Frequency of Verification:

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

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.

- 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.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: 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.), and implementing rules

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;
• 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.

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):*

(1) 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.

(2) 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.

(3) 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.

(4) Skilled Nursing services also include consulting services (i.e. assessments and health-related training and education for persons and caregivers).

(5) These services may address healthcare needs related to prevention and primary care activities. Consultative services must be performed by a Registered Nurse.

(6) Skilled Nursing services may be delivered in the home or community, based upon where the services are needed, and subject to the following exclusions:

(a) Skilled Nursing as an Extended State Plan service is only authorized for persons served through the waiver who live in their natural homes.

(b) 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**

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:	Sub-Category 1:
14 Equipment, Technology, and Modifications	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 are 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 a clinical evaluation, or by 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, or otherwise providing for the acquisition of assistive technology devices for persons served through the waiver; (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; or (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.

Allowable Assistive Technology items include:
Remotes and switches, service animals, mobile applications, smart home devices for completing activities of daily living, electronic motion sensor devices, door alarms, web cameras, telephones with modifications such as large buttons, telephones with flashing lights, phones equipped with picture buttons programmed with that person’s phone number, devices that may be affixed to a wheelchair or walker to send an alert when someone falls (these maybe slightly different than a PERS), text-to-speech software, devices that enhance images for people with low vision, intercom systems, other devices to enhance mobility and assist with performing daily tasks, virtual assistants/smart speakers, environmental controls devices, applications for prompting, and guidance and navigation.

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.

Services may be provided via remote support. Remote Supports is an electronic method of service delivery that enables a person to be more independent and less reliant on staff to be physically present to receive support. The remote caregiver can interact, coordinate supports, monitor, and/or respond to the person's needs through equipment capable of live two-way communication.

EFFECTIVE OCTOBER 1, 2022
Assistive technology items under $1,000 no longer require an assessment. DDS Service Provider can acquire technology based on the individual’s IDT/Support team justification of need in the individual’s support plan.

Assistive technology items over $1,000 must include AT assessment conducted by a professional of: Occupational Therapy; Physical therapy; Speech, Hearing and Language Services; Assistive Technology Professional (RESNA Certified); Certified Enabling Technology Integration Specialist (ETIS) employed by a SHIFT Accredited Waiver Service Provider; or another comparable national accreditation body, as approved by DDS.

Remote Supports:
1. Remote Supports is an electronic method of service delivery and can be delivered in four different delivery models:
a. Active Support: real-time oversight during scheduled times. The remote caregiver is monitoring the system in real-time and responding immediately as needed.
b. On-Demand Active Support: real-time oversight only when needed. This type of “as needed” live real-time

support is typically started when a triggering event occurs (from a sensor of some type) indicating the need for immediate support.
c. Scheduled Check-In: remote caregiver checks-in with the person at scheduled times. These are typically centered around ADL's or can be a simple wellness check.
d. Drop In: a remote caregiver checks-in at random times to ensure the wellness of the person supported to determine if they need any assistance.
2. The purpose of Remote Supports 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. Remote Support (RS) enables a person to be more independent and less reliant on staff to be physically present to receive support. The remote caregiver can interact, coordinate supports, monitor, and/or respond to the person's needs through equipment capable of live two-way communication.

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.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	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 Accredited DDS Service Provider

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 for 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: 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):*

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 vendor for 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:

Behavioral Supports

HCBS Taxonomy:

Category	Sub-Category
Category 1: 10 Other Mental Health and Behavioral Services	**Sub-Category 1:** 10040 behavior support
Category 2: 10 Other Mental Health and Behavioral Services	**Sub-Category 2:** 10030 crisis intervention
Category 3: 10 Other Mental Health and Behavioral Services	**Sub-Category 3:** 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. 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 persons with 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.

Services may be provided via remote support. Remote Supports is an electronic method of service delivery that enables a person to be more independent and less reliant on staff to be physically present to receive support. The remote caregiver can interact, coordinate supports, monitor, and/or respond to the person's needs through equipment capable of live two-way communication.

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.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency
Individual	Advanced Practice Registered Nurse
Individual	Licensed Clinical Social Worker
Individual	Licensed Professional Counselor

Provider Category	Provider Type Title
Individual	Behavior Specialist
Individual	Licensed Graduate Social Worker
Individual	Psychologist
Agency	Mental Health Core Service Agency

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):*

Certified Enabling Technology Integration Specialist (ETIS) employed by a SHIFT Accredited DDS Service Provider or Enabling Technology Credential (ETC)
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:

Advanced 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 Clinical Social Worker

Provider Qualifications

License *(specify):*

DCMR Title 17, Chapter 70/Social Worker

Certificate *(specify):*

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, LICSW, 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:

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 Master's degree in psychology when supervised by a licensed psychologist or a licensed clinical social worker.
The 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. 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:

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 (BCABA), in the jurisdiction where the credential is accepted.

Other Standard *(specify):*

Minimum qualifications for behavior specialist in consultation includes Master's 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:
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 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, LICSW, 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:

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 Master's degree in psychology when supervised by a licensed psychologist or a licensed clinical social worker. The minimum qualifications for consultation are Master's level psychologist, advanced practice nurse, LICSW, 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:
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: 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 is 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, Personal Care Services, Respite, 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. Additionally, companion services may not exceed forty (40) hours per week 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.

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

Companion services may be paired with In-Home Supports, 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, 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 and personal care services.

Companion services 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 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**

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):*

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;and COVID vaccination consistent with DC Health requirements.
• 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
The participant or authorized representative if designated as the common law employer of PDWs, and the VF/EA FMS-Support Broker entity determining if PDW has met minimum qualifications.

Frequency of Verification:

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: 11 Other Health and Therapeutic Services

Sub-Category 1: 11130 other therapies

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

The goal of Creative Arts Therapies services 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, and 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 as a one-to-one service for a person.

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

There is $2,250 per person, per calendar year cap for Creative Arts Therapy services.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Art Therapist; Dance Therapist; Music Therapist; Drama 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:

Art Therapist; Dance Therapist; Music Therapist; Drama Therapist

Provider Qualifications

License *(specify):*

- Art therapists certified to practice art therapy by the American Art Therapy Association, Inc. and/or credentialing of the Art Therapy Credentialing Board

Certificate *(specify):*

- Art therapists certified to practice art therapy by the American Art Therapy Association, Inc. and/or credentialing of the Art Therapy Credentialing Board

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

- Drama Therapists certified by the National Association for Drama Therapy

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: 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:

In-Home Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

This is a statutory service, but the "other" box is checked to allow submission
In-Home Supports are provided to a person living independently or with family or friends and not receiving other residential supports, and 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, 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 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. However In Home Supports services by phone or other technological means cannot exceed 20% of the total In Home Supports services that the person receives each week.

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 are available to support the person. These can include but not limited to from the person requiring additional supports returning home from hospitalization and/or rehabilitation; the primary care taker 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 resource 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.

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.
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 be associated with any risks identified. Goals are accomplished using HCBS, State Plan, and other identified 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.

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 until the situation has stabilized.

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-IFS 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**

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: Other 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

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
• Annual dDocumentation from a physician or other official that the employee is free from communicable disease as confirmed by a n annual purified protein derivative of tuberculin (PPD) Skin Test in accordance with current Centers for Disease Control (CDC) guidelines; and COVID vaccination consistent with DC Health requirements.
• 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.).

Participant-directed workers (PDWs) must meet the following qualifications:
a. Be at least eighteen (18) years of age;
b. Complete and pass a criminal background check pursuant to the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999, as amended by the HealthCare 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.);
c. Receive customized training provided by the participant and/or his/her authorized representative;
d. Be able and willing to provide the service-related responsibilities outlined in the participant's person-centered ISP;
e. Receive required trainings and certifications to meet the qualifications as a direct support professional (DSP) and maintain current certifications;
f. Not be a participant in the My Life My Way program;
g. Have an individual NPI number obtained from the National Plan and Provider Enumeration System (NPPES); and
h. Must register NPI number and complete application for PDWs in the Provider Data Management System (PDMS).

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual Directed Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

The item or service would:
o Decrease the need for other Medicaid services; and/or
o Promote inclusion in the community; and/or
o Increase the waiver participant's safety in the home environment.

Allowable goods and services shall include, but not be limited to, the following:

a. Fitness memberships
b. Fitness items that can be purchased at most retail stores
c. Toothbrushes or electric toothbrushes
d. Weight loss program services (other than food)
e. Dental services recommended by a licensed dentist and not covered by health insurance
f. Nutritional supplements recommended by a professional licensed in the relevant field
g. Therapeutic swimming or horseback riding with recommendation from licensed professional
h. Fees for activities that promote community integration
i. Fingerprinting, drug testing costs needed for the person to be considered for a job but not otherwise covered
j. Garage door opener for access to home
k. Non-post-secondary educational classes that are open to the general public and that offer the opportunity for community integration and engagement while the person is engaged in skill building or a hobby (for example, cooking class; fitness class; money management; art)
l. Durable medical equipment prescribed by a physician but not otherwise covered through health insurance
m. Flat rate/boarding rate associated with transportation services or other transportation services not currently available under Medicaid or the District's transportation system
n. Security deposit
o. Cleaning service from firms or individuals to clean the waiver participant's personal areas
a. Including bedroom, bathroom, kitchen, etc.
p. Food preparation service and delivery of prepared foods (does not provide payment for the food)
q. Small electric appliances which allow the participant to safely prepare meals
r. Laundry service from a Laundromat or other provider.
s. The cost of changing locks at the participant's home, as necessary, e.g. when a participant-directed worker terminates employment with the participant; and
t. Funding up to $500 that participants may choose to support staff recruitment and advertisement efforts such as developing and printing flyers and using staffing registries.

Individual-directed goods and services are only available to waiver participants who are enrolled in the My Life My Way program, which is the participant-directed services (PDS) program in the DDS IFS Waiver. Furthermore, individual-directed goods and services are only available if the individual does not otherwise have the funds to purchase the good or service or the good or service is not available through another source. Individual-directed goods and services are purchased from the participant's PDS budget. Experimental or prohibited treatments are excluded. Individual- directed goods and services must be documented in the participant's person-centered service plan and approved by DDS.

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

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

Upon revising a PDS budget to reflect a new individual-directed good or service, the support broker will submit the revised PDS budget to the My Life My Way Program Coordinator for approval. The Program Coordinator must approve any individual-directed good or service requested. Upon approval, the My Life My Way Program Coordinator will submit the amended PDS budget to the Vendor Fiscal/Employer Agent (VF/EA) Financial Management Services (FMS)-Support Broker entity, allowing the VF/EA FMS-Support Broker entity to authorize payment of vendor invoices submitted for the approved individual-directed goods and services.

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

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

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Directed Goods and Services

Provider Category:

Individual

Provider Type:

Individual/Vendor as selected by the participant

Provider Qualifications

License *(specify):*

Valid Business License in good standing, if applicable

Certificate *(specify):*

N/A

Other Standard *(specify):*

All individuals/vendors providing individual-directed goods and services must be at least eighteen (18) years of age. All individuals/vendors must be able to:

(1) demonstrate to the waiver participant that they have the capacity to perform the requested work and

the ability to successfully communicate with him/her; and

(2) have all necessary professional and/or commercial licenses required by federal, state and local statutes and regulations, if applicable.

Individuals/vendors providing non-medical transportation as an individual-directed service must have:

(1) a valid driver's license; and

(2) the minimum amount of liability insurance required by the District of Columbia for the type of vehicle used to provide the transportation.

Furthermore, if applicable, individuals/vendors shall enter into a Medicaid provider agreement, as required by CMS, which shall be executed by the VF/EA FMS-Support Broker entity on behalf of DHCF.

Verification of Provider Qualifications

Entity Responsible for Verification:

VF/EA FMS-Support Broker entity.

Frequency of Verification:

At time of enrollment and thereafter as necessary.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual Supported Employment

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:

03 Supported Employment

Sub-Category 3:

03022 ongoing supported employment, group

Service Definition *(Scope):*

Category 4:

03 Supported Employment

Sub-Category 4:

03030 career planning

This is a statutory service, but the "other" box is checked to allow submission
Supported Employment 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 or small groups of people with disabilities in the community, [ADD] but may be appropriate for small group supported employment to the extent that the setting meetings 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. However such Supported Employment services by phone or other technological means cannot exceed 20% of the total Supported Employment services that the person receives each week.

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.

Services may be provided via remote support. Remote Supports is an electronic method of service delivery that enables a person to be more independent and less reliant on staff to be physically present to receive support. The remote caregiver can interact, coordinate supports, monitor, and/or respond to the person's needs through equipment capable of live two-way communication.

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.
Time spent in transportation to and from the program shall not be included in the total amount of services provided per day.
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 IFS Waiver individuals, this benefit is only used by IFS waiver beneficiaries 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 Individual Supported Employment. Individual Supported Employment 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**

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: Individual 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 SHIFT Accredited DDS Service Provider or Enabling Technology Credential (ETC)

Other Standard *(specify):*

Provider enrolled to provide services through DDS/DHCF and has current Medicaid agreement.
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; and COVID vaccination consistent with DC Health requirements.
- 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 DDC approved pre-services 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 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:

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:**
12 Services Supporting Self-Direction	
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 day habilitation 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.

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

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 participating in Senior Centers, or working on adult skill development in natural community based settings, 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). 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 IFS Waiver individuals, this benefit is only used by IFS 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-IFS 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 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**

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	Individual Day Support

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:

Individual Day Support

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; and COVID vaccination consistent with DC Health requirements;
• 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. Law12-238), 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, $544-55 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.

Participant-directed workers (PDWs) must meet the following qualifications:
a. Be at least eighteen (18) years of age;
b. Complete and pass a criminal background check pursuant to the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999, as amended by the HealthCare 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.);
c. Receive customized training provided by the participant and/or his/her authorized representative;
d. Be able and willing to provide the service-related responsibilities outlined in the participant’s person-centered ISP;
e. Receive required trainings and certifications to meet the qualifications as a direct support professional (DSP) and maintain current certifications;
f. Not be a participant in the My Life My Way program;
g. Have an individual NPI number obtained from the National Plan and Provider Enumeration System (NPPES); and
h. Must register NPI number and complete application for PDWs in the Provider Data Management System (PDMS).

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

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 to meet the therapeutic goals. This is not an extended state plan service. This service may be used in addition to or in place of the state plan service if indicated as needed by the physician. This service differs from the state plan service by provider qualifications and locations where service may be delivered. The Occupational Therapist, under the HCBS waiver, is not restricted to those employed by hospital or clinics. This service is delivered by a licensed practitioner and is delivered in the individual's home or day service setting.

Services may be provided via remote support. Remote Supports is an electronic method of service delivery that enables a person to be more independent and less reliant on staff to be physically present to receive support. The remote caregiver can interact, coordinate supports, monitor, and/or respond to the person's needs through equipment capable of live two-way communication.

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 remote services engagement to determine how many hours the person can engage in remote supports for occupational therapy. Occupational Therapy 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**

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	Occupational Therapist

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):*

Certified Enabling Technology Integration Specialist (ETIS) employed by a SHIFT Accredited DDS Service Provider or Enabling Technology Credential (ETC)

Other Standard *(specify):*

Local IDD Waiver providers who have been certified to provide Remote Support Services can provide this service. Remote Support Services may also be sub-contracted to vendors who provide Remote Support Services monitoring.Providers furnishing Remote Supports must meet the following requirements:
a. Complete SHIFT Training
b. The Remote Support Provider shall provide initial and ongoing training to its staff to ensure they know how to use the monitoring equipment
c. Remote support shall be provided in real time, not via a recording, by awake staff at a Monitoring location using the appropriate connection. While remote support is being provided, the remote support staff shall not have duties other than remote support.
d. The Remote Support Provider shall have a backup power system (such as battery power) in place at the remote monitoring location site in the event of electrical outages. Please note: This requirement only applies to In-home Supports and the Supported Living Periodic-Remote Service.
e. If services are unable to be delivered remotely, the backup support person shall arrive at the individual’s locating within 30 minutes when a request for in-person assistance is made.
f. The Remote Support Vendor shall provide an individual who receives remote support with initial and ongoing training on how to use the remote support system as specified in the individual service plan.

g. The remote support staff shall have detailed and current written protocols for responding to an individual's needs as specified in the individual service plan, including contact information for the backup support person to render assistance when necessary and times when remote support will be provided.
h. The Remote Support Vendor shall have an effective procedure for notifying emergency personnel such as police, fire, emergency medical services, and psychiatric crisis response entities.

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:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

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

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: 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:**

Service Definition *(Scope):*

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

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.

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 In Home Supports providers and can be offered in combination with any waiver residential services.

Services may be provided via remote support. Remote Supports is an electronic method of service delivery that enables a person to be more independent and less reliant on staff to be physically present to receive support. The remote caregiver can interact, coordinate supports, monitor, and/or respond to the person's needs through equipment capable of live two-way communication.

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 remote services engagement to determine how many hours the person can engage in remote supports for parenting support. Parenting support 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**

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 IFS Waiver services: In-Home Supports.

Local IDD Waiver providers who have been certified to provide Remote Support Services can provide this service. Remote Support Services may also be sub-contracted to vendors who provide Remote Support Services monitoring.Providers furnishing Remote Supports must meet the following requirements:
a. Complete SHIFT Training
b. The Remote Support Provider shall provide initial and ongoing training to its staff to ensure they know how to use the monitoring equipment
c. Remote support shall be provided in real time, not via a recording, by awake staff at a Monitoring location using the appropriate connection. While remote support is being provided, the remote support staff shall not have duties other than remote support.
d. The Remote Support Provider shall have a backup power system (such as battery power) in place at the remote monitoring location site in the event of electrical outages. Please note: This requirement only applies to In-home Supports and the Supported Living Periodic-Remote Service.
e. If services are unable to be delivered remotely, the backup support person shall arrive at the

individual's locating within 30 minutes when a request for in-person assistance is made.
f. The Remote Support Vendor shall provide an individual who receives remote support with initial and ongoing training on how to use the remote support system as specified in the individual service plan.

g. The remote support staff shall have detailed and current written protocols for responding to an individual's needs as specified in the individual service plan, including contact information for the backup support person to render assistance when necessary and times when remote support will be provided.
h. The Remote Support Vendor shall have an effective procedure for notifying emergency personnel such as police, fire, emergency medical services, and psychiatric crisis response entities.

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 services. 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:

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	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.
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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: 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 case manager 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**

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

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: 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: 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

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 ISP/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 as a one-to-one service for a person.

Services may be provided via remote support. Remote Supports is an electronic method of service delivery that enables a person to be more independent and less reliant on staff to be physically present to receive support. The remote caregiver can interact, coordinate supports, monitor, and/or respond to the person's needs through equipment capable of live two-way communication.

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 remote services engagement to determine how many hours the person can engage in remote supports for Speech, Hearing, and Language Services. Speech, Hearing, and Language 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**

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	Speech Pathologists
Individual	Audiologists

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech, Hearing, and Language

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):*

Certified Enabling Technology Integration Specialist (ETIS) employed by a SHIFT Accredited DDS Service Provider or Enabling Technology Credential (ETC)

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 this service. Remote Support Services may also be sub-contracted to vendors who provide Remote Support Services monitoring. Providers furnishing Remote Supports must meet the following requirements:
a. Complete SHIFT Training
b. The Remote Support Provider shall provide initial and ongoing training to its staff to ensure they know how to use the monitoring equipment
c. Remote support shall be provided in real time, not via a recording, by awake staff at a Monitoring location using the appropriate connection. While remote support is being provided, the remote support staff shall not have duties other than remote support.
d. The Remote Support Provider shall have a backup power system (such as battery power) in place at the remote monitoring location site in the event of electrical outages. Please note: This requirement only applies to In-home Supports and the Supported Living Periodic-Remote Service.
e. If services are unable to be delivered remotely, the backup support person shall arrive at the individual's locating within 30 minutes when a request for in-person assistance is made.
f. The Remote Support Vendor shall provide an individual who receives remote support with initial and ongoing training on how to use the remote support system as specified in the individual service plan.

g. The remote support staff shall have detailed and current written protocols for responding to an individual's needs as specified in the individual service plan, including contact information for the backup support person to render assistance when necessary and times when remote support will be provided.
h. The Remote Support Vendor shall have an effective procedure for notifying emergency personnel such as police, fire, emergency medical services, and psychiatric crisis response entities.

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

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):*

Other Standard *(specify):*

Certificate of Clinical Competence in the area of Audiology granted by the American Speech Hearing Language Association

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:

Unpaid Family/Caregiver 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):*

Unpaid Family/Caregiver Training services are training, counseling, and other professional support services offered to uncompensated caregivers who provide support, training, companionship, or supervision to persons enrolled in the IFS 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, as well as transition support. 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 unpaid caregiver training and counseling must be included in the individual's person's plan.

Unpaid Family/Caregiver Training is available as a one-to-one service for a person.

Unpaid Family/Caregiver Training may be delivered by clinical professionals or by qualified peers. A qualified peer is an individual who meets the qualifications and standards as a family training provider.

Unpaid Family/Caregiver Training peer services are arranged by DDS certified provider organizations.

Services may be provided via remote support. Remote Supports is an electronic method of service delivery that enables a person to be more independent and less reliant on staff to be physically present to receive support. The remote caregiver can interact, coordinate supports, monitor, and/or respond to the person's needs through equipment capable of live two-way communication.

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.

Reimbursement is not available for costs of travel, meals, and overnight lodging to attend a training event or conference. Reimbursement is available for costs of registration and training fees associated with formal instruction in areas relevant to the needs of the person enrolled in the IFS waiver, as identified within their service plan.

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 Unpaid Family/Caregiver Training peer services. Unpaid Family/Caregiver Training peer 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**

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	Educator
Agency	Home Care Agency; Family Training Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Unpaid Family/Caregiver Training

Provider Category:
Individual
Provider Type:

Educator

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Teacher's Certification in DC, MD or VA.
Teachers must hold a Master's Degree in Special Education from an accredited college or university.
Certified Enabling Technology Integration Specialist (ETIS) employed by a SHIFT Accredited DDS Service Provider or Enabling Technology Credential (ETC)

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 this service. Remote Support Services may also be sub-contracted to vendors who provide Remote Support Services monitoring. Providers furnishing Remote Supports must meet the following requirements:
a. Complete SHIFT Training
b. The Remote Support Provider shall provide initial and ongoing training to its staff to ensure they know how to use the monitoring equipment
c. Remote support shall be provided in real time, not via a recording, by awake staff at a Monitoring location using the appropriate connection. While remote support is being provided, the remote support staff shall not have duties other than remote support.
d. The Remote Support Provider shall have a backup power system (such as battery power) in place at the remote monitoring location site in the event of electrical outages. Please note: This requirement only applies to In-home Supports and the Supported Living Periodic-Remote Service.
e. If services are unable to be delivered remotely, the backup support person shall arrive at the individual's locating within 30 minutes when a request for in-person assistance is made.
f. The Remote Support Vendor shall provide an individual who receives remote support with initial and ongoing training on how to use the remote support system as specified in the individual service plan.

g. The remote support staff shall have detailed and current written protocols for responding to an individual's needs as specified in the individual service plan, including contact information for the backup support person to render assistance when necessary and times when remote support will be provided.
h. The Remote Support Vendor shall have an effective procedure for notifying emergency personnel such as police, fire, emergency medical services, and psychiatric crisis response entities.

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: Unpaid Family/Caregiver Training

Provider Category:
Agency
Provider Type:

Home Care Agency; Family Training Provider

Provider Qualifications

License *(specify):*

Home Care Agency:
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 LicensingAdministration).

Certificate *(specify):*

Other Standard *(specify):*

Family Training Provider:
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 that from a physician or other official that the employee is free from communicable disease as confirmed by an annual PPT skin test; and COVID vaccination consistent with DC Health requirements.
- 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, DOH, HRLA

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:

Wellness Services

HCBS Taxonomy:

Category	Sub-Category
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 are direct services to people served through the waiver, based on need and specified in an approved ISP/Plan of Care.

Wellness Services offered are as follows:
• Massage Therapy
• Sexuality Education that provides training in sexuality awareness, reproduction education, safe sexual practices, and victimization avoidance;
• 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 ISP/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.

A person may utilize one or more Wellness Services in the same day, but not at the same time.

Wellness Services, with the exception of Massage Therapy, may be provided via remote support. Remote Supports is an electronic method of service delivery that enables a person to be more independent and less reliant on staff to be physically present to receive support. The remote caregiver can interact, coordinate supports, monitor, and/or respond to the person's needs through equipment capable of live two-way communication.

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

Wellness services shall be limited to:
- Massage: 52 hours/ year with extension to 100 hours/ year with approved by DDA Deputy Director based upon assessed medical or clinical need (e.g., someone with CP who has severe contractures and would benefit from massage therapy).

- Sexuality Education: Limit to 52 hours/ year. An extension of additional hours, up to one hundred (100) hours per year, may be authorized before the expiration of the ISP/Plan of Care with approval by DDA Deputy Director based upon assessed medical or clinical need. 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 Sexuality Education. Sexuality Education services can be implemented partially in-person and partially remote supports.

- Fitness: Limit to 52 hours/ year for people who use In Home Supports or who otherwise have natural supports available who can help the person practice the skills they learn in fitness and achieve their fitness goals. Authorize up to 104 hours/ year for people who live in natural homes, without In-Home Supports, and who do not have such natural supports available (for example, people who live with aging parents). 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 Fitness. Fitness services can be implemented partially in-person and partially remote supports.

- Nutrition: Limit to 26 hours/ year and the person shall have natural or paid supports who can help them implement the learning and nutrition goals outside of the time with the nutritionist. 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 Nutrition. Nutrition services can be implemented partially in-person and partially remote supports.

- Bereavement Counseling: Must be requested by the person or recommended by the person's support team. Limited to those persons who have experienced a loss through death, relocation, change in family structure, or loss of employment. Limit one hundred (100) hours per ISP year per service. Additional hours may be authorized before the expiration of the ISP/Plan of Care 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 remote services engagement to determine how many hours the person can engage in remote supports for Bereavement Counseling. Bereavement Counseling 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**

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	Sexuality Education Specialist
Individual	Bereavement Counselor
Individual	Dietetic/Nutrition Counselor
Individual	Fitness Trainer
Individual	Massage Therapist

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):*

Certified Enabling Technology Integration Specialist (ETIS) employed by a SHIFT Accredited DDS Service Provider or Enabling Technology Credential (ETC)

Other Standard *(specify):*

Local IDD Waiver providers who have been certified to provide Remote Support Services can provide this service. Remote Support Services may also be sub-contracted to vendors who provide Remote Support Services monitoring. Providers furnishing Remote Supports must meet the following requirements:
a. Complete SHIFT Training
b. The Remote Support Provider shall provide initial and ongoing training to its staff to ensure they know how to use the monitoring equipment
c. Remote support shall be provided in real time, not via a recording, by awake staff at a Monitoring location using the appropriate connection. While remote support is being provided, the remote support staff shall not have duties other than remote support.
d. The Remote Support Provider shall have a backup power system (such as battery power) in place at the remote monitoring location site in the event of electrical outages. Please note: This requirement only applies to In-home Supports and the Supported Living Periodic-Remote Service.
e. If services are unable to be delivered remotely, the backup support person shall arrive at the individual’s locating within 30 minutes when a request for in-person assistance is made.
f. The Remote Support Vendor shall provide an individual who receives remote support with initial and ongoing training on how to use the remote support system as specified in the individual service plan.

g. The remote support staff shall have detailed and current written protocols for responding to an individual's needs as specified in the individual service plan, including contact information for the backup support person to render assistance when necessary and times when remote support will be provided.
h. The Remote Support Vendor shall have an effective procedure for notifying emergency personnel such as police, fire, emergency medical services, and psychiatric crisis response entities

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:

Sexuality Education Specialist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

(a) A Sexuality Education Specialist who is certified to practice sexuality education by the American Association of Sexuality Educators, Counselors and Therapists Credentialing Board; or

(b) Any of the following professionals with specialized training in Sexuality Education:
(1) Psychologist;
(2) Psychiatrist;
(3) Licensed Clinical Social Worker;
(4) Licensed Professional Counselor; or
(5) Other equivalent national certification as approved by DDS.

Certified Enabling Technology Integration Specialist (ETIS) employed by a SHIFT Accredited DDS Service Provider or Enabling Technology Credential (ETC)

Other Standard *(specify):*

Local IDD Waiver providers who have been certified to provide Remote Support Services can provide this service. Remote Support Services may also be sub-contracted to vendors who provide Remote Support Services monitoring. Providers furnishing Remote Supports must meet the following requirements:
a. Complete SHIFT Training
b. The Remote Support Provider shall provide initial and ongoing training to its staff to ensure they know how to use the monitoring equipment
c. Remote support shall be provided in real time, not via a recording, by awake staff at a Monitoring location using the appropriate connection. While remote support is being provided, the remote support staff shall not have duties other than remote support.
d. The Remote Support Provider shall have a backup power system (such as battery power) in place at the remote monitoring location site in the event of electrical outages. Please note: This requirement only applies to In-home Supports and the Supported Living Periodic-Remote Service.
e. If services are unable to be delivered remotely, the backup support person shall arrive at the individual's locating within 30 minutes when a request for in-person assistance is made.
f. The Remote Support Vendor shall provide an individual who receives remote support with initial and ongoing training on how to use the remote support system as specified in the individual service plan.

g. The remote support staff shall have detailed and current written protocols for responding to an individual's needs as specified in the individual service plan, including contact information for the backup support person to render assistance when necessary and times when remote support will be provided.
h. The Remote Support Vendor shall have an effective procedure for notifying emergency personnel such as police, fire, emergency medical services, and psychiatric crisis response entities

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:

Bereavement Counselor

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
Certified Enabling Technology Integration Specialist (ETIS) employed by a SHIFT Accredited DDS Service Provider or Enabling Technology Credential (ETC)

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 this service. Remote Support Services may also be sub-contracted to vendors who provide Remote Support Services monitoring. Providers furnishing Remote Supports must meet the following requirements:
a. Complete SHIFT Training
b. The Remote Support Provider shall provide initial and ongoing training to its staff to ensure they know how to use the monitoring equipment
c. Remote support shall be provided in real time, not via a recording, by awake staff at a Monitoring location using the appropriate connection. While remote support is being provided, the remote support staff shall not have duties other than remote support.
d. The Remote Support Provider shall have a backup power system (such as battery power) in place at the remote monitoring location site in the event of electrical outages. Please note: This requirement only applies to In-home Supports and the Supported Living Periodic-Remote Service.
e. If services are unable to be delivered remotely, the backup support person shall arrive at the individual’s locating within 30 minutes when a request for in-person assistance is made.
f. The Remote Support Vendor shall provide an individual who receives remote support with initial and ongoing training on how to use the remote support system as specified in the individual service plan.

g. The remote support staff shall have detailed and current written protocols for responding to an individual's needs as specified in the individual service plan, including contact information for the backup support person to render assistance when necessary and times when remote support will be provided.
h. The Remote Support Vendor shall have an effective procedure for notifying emergency personnel such as police, fire, emergency medical services, and psychiatric crisis response entities

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):*

Certified Enabling Technology Integration Specialist (ETIS) employed by a SHIFT Accredited DDS Service Provider or Enabling Technology Credential (ETC)

Other Standard *(specify):*

Local IDD Waiver providers who have been certified to provide Remote Support Services can provide this service. Remote Support Services may also be sub-contracted to vendors who provide Remote Support Services monitoring. Providers furnishing Remote Supports must meet the following requirements:
a. Complete SHIFT Training
b. The Remote Support Provider shall provide initial and ongoing training to its staff to ensure they know how to use the monitoring equipment
c. Remote support shall be provided in real time, not via a recording, by awake staff at a Monitoring location using the appropriate connection. While remote support is being provided, the remote support staff shall not have duties other than remote support.
d. The Remote Support Provider shall have a backup power system (such as battery power) in place at the remote monitoring location site in the event of electrical outages. Please note: This requirement only applies to In-home Supports and the Supported Living Periodic-Remote Service.
e. If services are unable to be delivered remotely, the backup support person shall arrive at the individual’s locating within 30 minutes when a request for in-person assistance is made.
f. The Remote Support Vendor shall provide an individual who receives remote support with initial and ongoing training on how to use the remote support system as specified in the individual service plan.

g. The remote support staff shall have detailed and current written protocols for responding to an individual's needs as specified in the individual service plan, including contact information for the backup support person to render assistance when necessary and times when remote support will be provided.
h. The Remote Support Vendor shall have an effective procedure for notifying emergency personnel such as police, fire, emergency medical services, and psychiatric crisis response entities

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):*

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

Certified Enabling Technology Integration Specialist (ETIS) employed by a SHIFT Accredited DDS Service Provider or Enabling Technology Credential (ETC)

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 this service. Remote Support Services may also be sub-contracted to vendors who provide Remote Support Services monitoring. Providers furnishing Remote Supports must meet the following requirements:
a. Complete SHIFT Training
b. The Remote Support Provider shall provide initial and ongoing training to its staff to ensure they know how to use the monitoring equipment
c. Remote support shall be provided in real time, not via a recording, by awake staff at a Monitoring location using the appropriate connection. While remote support is being provided, the remote support staff shall not have duties other than remote support.
d. The Remote Support Provider shall have a backup power system (such as battery power) in place at the remote monitoring location site in the event of electrical outages. Please note: This requirement only applies to In-home Supports and the Supported Living Periodic-Remote Service.
e. If services are unable to be delivered remotely, the backup support person shall arrive at the individual's locating within 30 minutes when a request for in-person assistance is made.
f. The Remote Support Vendor shall provide an individual who receives remote support with initial and ongoing training on how to use the remote support system as specified in the individual service plan.

g. The remote support staff shall have detailed and current written protocols for responding to an individual's needs as specified in the individual service plan, including contact information for the backup support person to render assistance when necessary and times when remote support will be provided.
h. The Remote Support Vendor shall have an effective procedure for notifying emergency personnel such as police, fire, emergency medical services, and psychiatric crisis response entities

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:

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: Summary of Services Covered (2 of 2)

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

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

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

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

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

The Service Coordinator (formerly known as Case Manager) from DHCF's delegated operating agency, the Department on Disability Services (DDS), coordinates case management for persons receiving IFS waiver services.

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; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request

through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

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

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

Appendix C: Participant Services

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

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

- (●) **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

- [ ] **Self-directed**
- [ ] **Agency-operated**

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

- ( ) **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- (●) **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

For all waiver services, payments are not made to legal guardians, including a parent of a minor child, spouse, or legal guardian of an adult. Payments are made to relatives, defined as siblings, grandparents, aunts, uncles, cousins or the parent of an adult child.

In order to receive payment for any waiver service, Relatives:
1. Must become an employee of the participant's chosen waiver-enrolled provider agency, OR
2. Must be an enrolled waiver service/Medicaid provider (agency or individual).
The following waiver services may be offered by relatives:
In-home supports;
Parenting Supports;
Personal Care;
Respite;
Family Training; and
Individualized Day Supports.
Relatives may be paid for providing this service whenever the service specifications in Appendix C-3 are met for participants who are at least eighteen years of age. Relatives may serve as
either the contracted worker or the chosen waiver enrolled agency, but not both. The relative must meet the same standards as other employees or contractors non-related to the participant. The relative contracted as the worker must be at least 18 years of age. The relative contracted as the worker is responsible for maintaining records in accordance with all District and provider requirements. A relative serving as a worker must meet all standards established by the District, and is responsible for duties as outlined in Appendix C-3 and accompanying waiver manual. As outlined in the Plan of Care, payment for services rendered is approved by prior and post authorization.

Services provided by the relative are reviewed during the ISP meeting to evaluate the effectiveness of the current or prospective service provision. Services provided by a relative are discussed to ensure that the participant freely chooses to have the relative deliver the service, is properly supervised by the enrolled service agency and case manager for any developing conflicts of interest, and continues to meet the outcomes identified in the ISP.

All workers must be affiliated with a provider and are subject to all standard provider oversight described in this waiver application. Any indication that Medicaid guidelines are not being met leads to an investigation that may result in the recovery of payments made to the provider. There are no unique service limits applied to relatives delivering services as authorized in the ISP. Additionally, a relative may provide services as a participant directed worker for In Home Supports.

○ **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.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
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:

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

requirements.

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

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

Performance Measure:
QP.a.i.b.PM.1. Percentage of non-licensed/non-certified providers that maintain compliance with waiver requirements. Number of non-licensed/non-certified providers that adhered to waiver requirements (numerator) / Number of non-licensed/non-certified providers reviewed (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:

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**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **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 IFS Waiver program).

Providers that have not previously been certified for any services by DDS will be subject to "pre-qualification" requirements conducted by the Provider Relations Unit 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 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 IFS HCBS waiver program.

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

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 an EXCEL spreadsheet 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:

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 and how they meet federal HCB Settings requirements, at the time of submission and in the

future.

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

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

The District 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.

The District assures that all home and community-based settings are, at a minimum:
• Integrated in and supports full access to the greater community, including 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;
• 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;
• Ensures individual 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; and
• Facilitates choice regarding services and who provides them.
In accordance that 441.301(c)(5)(v), this waiver does not include settings that are presumed to have institutional qualities, and do not meet the threshold for Medicaid HCBS. Excluded settings include those:
• That is located in a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment,
• That is located in a building on the grounds of, or immediately adjacent to, a public institution, or
• That has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

Additionally, there are no provider-owned or controlled home and community-based residential settings authorized in this waiver.

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.

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 *(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:

Persons with a Bachelor's degree in a human service related field and one year experience in direct service with people with intellectual or developmental disabilities; or

Persons with a Bachelor's degree in any field and three (3) years experience working with people with intellectual or developmental disabilities under the supervision of a QDDP.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The initial ISP / Plan of Care (POC) meeting is developed within ninety (90) days of enrollment in the IFS HCBS Waiver. Prior to the completion of the initial ISP / Plan of Care(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 person is also educated and provided a fact sheet on how to identify and report abuse, neglect, and exploitation.

The ISP/Plan of Care 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/Plan of Care (POC) meeting, the Service Coordinator meets with the person (and their family/legal representatives, as appropriate). The meeting is conducted face-to-face at the person’s location of choice, or the offices of the Department on Disability Services, or by phone depending on which is more convenient for the person and not his/her service coordinator or other team members.

During this visit/meeting, the person chooses who will be part of his/her planning process as their team. The Service Coordinator assists the person in contacting the team members with date, location, and time of the meeting. Additionally, for the annual ISP/POC, this meeting is used to assist the person in reviewing his/her progress in meeting the previous year’s goals. The person’s preferences, needs, goals, and desires for the next year are discussed. 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 Plan of CareISP year which requires consideration of a provider change. The Service Coordinator has the responsibility of ensuring that this information drives the development of the Plan of CareISP. A standardized person-centered planning format is used throughout the ISP/Plan of Care 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. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Individual Support Plan (ISP)/Plan of Care 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/Plan of Care meeting and no later than thirty (30) days following the meeting, the DDS Service Coordinator's supervisor reviews and approves the Plan of CareISP. The supervisor is responsible for ensuring that the waiver services are clearly delineated and justified based upon the needs identified in the Plan of CareISP and its accompanying assessments. The ISP/Plan of Care is implemented within thirty (30) days of the ISPPlan of Care 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/Plan of Care 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 /Plan of Care 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 ISPPlan of Care. The requirement of this information and its inclusion in the Plan of CareISP 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 Plan of CareISP. The requirement of this information and its inclusion in the Plan of Care/ISP ensures the individual's identified outcomes, needs, and preferences are appropriately addressed.

(d) Waiver and other identified services in the ISP /Plan of Care are coordinated through the Service Coordinator. Service coordinators are required to make monthly contact with each individual, and conduct a face-to-face visit with the individual on a quarterly basis. During eight (8) of these monthly contacts, Service Coordinators review information in the ISP/Plan of Care, track progress on identified goals and timelines, and get updated information on the progress of informal/unpaid supports identified in the ISP/Plan of Care. 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/Plan of Care, and for the Service Coordinator to request a reassessment or a new assessment.

1) Each goal identified in the ISP/Plan of Care 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/Plan of Care, 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 Plan of CareISP to determine if the goals identified in the ISP/Plan of Care 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.
4) The Service Coordinator shall monitor the utilization of authorized waiver services to ensure that person does not exceed the annual spending cap.

(f) The ISP/Plan of care must be revised annually or as necessary to meet the needs of the individual. The Service Coordinator is tasked with arranging any necessary assessments and 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/Plan of Care meeting is always completed before the anniversary date of the current Plan of CareISP. The Service Coordinator is solely responsible for ensuring that the Plan of CareISP is conducted in accordance with DDS requirements and is with best practices in the field of developmental disabilities. Mid Plan of Care cycle changes that require ISP/Plan of Care revision are coordinated by the Service Coordinator, Documentation for the ISP/Plan of Care 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/Plan of Care or return it to the Service Coordinator for any necessary, additional information.

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 individual and their 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 meetings and be updated as needed at the time. The Service Coordinator will note any changes in the LON and determine if natural, community-based, or State Plan Medicaid services could meet any increased support need indicated in the LON.

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 Plan of CareISP.

The emergency back-up plan is a core component of the ISP/Plan of Care 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/Plan of Care. 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 Plan of CareISP.
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 in the individual's Plan of CareISP.

Back-up plans are updated no less than annually through the ISP/Plan of Care process to assure information is kept current and applicable to the individual'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 individual.

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 the services available under the 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 Individual Support Plans (ISPs) 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 of 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 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 and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

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 eight (8) of these monthly contacts, Service Coordinators review information on the ISP/Plan of Care, track progress on identified goals and timelines, and get updated information on the progress of informal/unpaid supports identified in the ISP/Plan of Care.
• During the development of the ISP/Plan of Care, 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 Intake and Eligibility determination procedures, if it's determined that the person would benefit from Waiver services the Community Outreach Liaison will discuss the waiver application with the person and his/her support team. During this time, the Freedom of Choice form is completed which documents the person's informed choice regarding accessing services through the HCBS IFS 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. The emergency back-up plan is a core component of the ISP/Plan of Care format. 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/Plan of Care.
• 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/Plan of Care 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 Plan ISP.
• Service Coordinator supervisors review a sample of ISP's 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 which 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 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 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.

The supervisory service coordinator conducts sample reviews of ISP's to ensure the completion of the back up plan. The effectiveness of the back up plan is checked through monthly ISP reviews and service coordination monitoring visits.

b. Monitoring Safeguards. *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
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:

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

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: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

Performance Measure:
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:

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: 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.d.PM.1. Percentage of people that receive services as described in the ISP in type, scope, amount, duration, and frequency. Total number of people that receive services as described in the ISP in type, scope, amount, duration and frequency (numerator) / Total number of unduplicated people reviewed (denominator).

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: 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.e.PM.2. Percentage of people whose records have signed evidence of a choice of services and providers. Number of people whose records have signed evidence that he/she was offered choice of services and service providers (numerator) / Total number of service plans reviewed (denominator).

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

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. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

All waiver participants will have the opportunity to: (1) exercise employer authority to recruit, hire, supervise and discharge qualified participant-directed workers (PDWs) who provide participant-directed services (PDS) and (2) exercise budget authority to purchase allowable and approved individual-directed goods and services using a PDS budget. Financial Management Services (FMS) and Support Broker services will be provided as administrative activities by a single, District-wide Vendor Fiscal/Employer Agent (VF/EA) FMS-Support Broker entity selected through a request for proposal (RFP) process. The IDT Team will discuss services based on the persons' specified need(s) and the most appropriate waiver will be explored for enrollment in the IFS Waiver. Waiver participants whose needs would be appropriately met in the IFS Waiver will be enrolled choose to enroll in the My Life My Way program and self-direct their In-Home Supports, Individualized Day Supports (IDS), Companion Services and individual directed goods and services, in which will have access to other traditional services available under the IFS waiver. Thus, waiver participants may elect to receive either traditional HCBS or participant-directed HCBS or a combination of both. Duplication of services will not occur. How Participants Access Participant-Directed Services: Both current and new waiver participants will have the opportunity to elect to enroll in the My Life My Life Way program and self-direct approved In-Home Supports, Individualized Day Supports (IDS), Companion Services and individual-directed goods and services.

Current Waiver Participants: – For current waiver participants, when enrollment begins for the My Life My Way program, the assigned waiver Service Coordinator will inform each waiver participant about the program and the opportunity to self-direct In-Home Supports, individualized day supports (IDS), respite, companion services and individual-directed goods and services using standard, easily understandable information approved by DDS. The process will be repeated each time a waiver participant is reassessed for services and his/her person-centered ISP is updated if he/she is not enrolled in the My Life My Way program. All current waiver participants will have the option to enroll in the My Life, My Way program and develop a new person-centered ISP and a PDS budget that includes in-home supports, individualized day supports, respite, companion services and individual-directed goods and services. The waiver case manager will discuss the traditional and participant-directed service delivery options to ensure each waiver participant understands the different opportunities available, their roles and responsibilities and options for receiving supports. If a waiver participant wishes to enroll in the My Life My Way program, the waiver Service Coordinatorcase manager will have the participant complete a Consumer Inquiry Form and provide a copy to DDS or its designee. Then, the waiver case manager will review the requirements of the program with the participant and oversee their signing of the Participant Consent Form. The waiver Service Coordinator will also develop, with the waiver participant, a revised person-centered ISP, including the participant-directed service option and a risk mitigation plan using a person-centered approach. He/she will also compute the waiver participant's PDS monthly allocation amount using a standard methodology developed by DHCF. The Service Coordinator waiver case manager will send the executed Participant Consent Form along with the waiver participant's revised person-centered ISP, risk mitigation plan and PDS monthly allocation amount to DDS or its designee. DDS or its designee will then forward these documents and a referral for enrollment into the My Life My Way program to the VF/EA FMS Support Broker entity. The VF/EA FMS-Support Broker entity will assign a support broker to the waiver participant and commence the enrollment process. The PDS budget, developed by the waiver participant and his/her support broker, will be submitted to DDS or its designee for review and approval. The support broker will conduct a comprehensive orientation and training with the waiver participant/representative-employer using standard, easy to understand materials approved by DDS. The support broker will also assist the participant/representative employer in completing forms and agreements and providing required information as requested in the Participant/Representative Employer Enrollment Packet and PDW Employment and Individual-Directed Goods and Services Vendor Engagement Packet prepared and distributed by the VF/EA FMS-Support Broker entity and any other forms and/or agreements, as required by DDS. New Waiver Participants – New waiver participants will be connected with waiver services through the Developmental Disabilities Administrations (DDA) and the Service Coordinator will provide comprehensive options counseling and introduce IFS waiver applicants to the My Life My Way program and participant-directed services using standard, easily understandable information approved by DDS. If an IFS waiver applicant expresses an interest in enrolling in the My Life My Way program, the Service Coordinator will assist the individual with completing a Consumer Inquiry Form. The form will be submitted to the DDS or its designee, who will contact the participant and his/her assigned Service Coordinator waiver case manager after the participant is enrolled in the IFS waiver regarding enrollment in the My Life My Way program. The participant will then work with the waiver Service Coordinator and support broker as described above for currently enrolled waiver participants.

Entities Supporting Individuals: The VF/EA FMS-Support Broker entity selected through an RFP will work with waiver participants enrolled in the My Life My Way program to provide support and facilitate their success in self-directing their approved In-Home supports, IDS, Companion Services and individual-directed goods and services and managing their PDS budget. The VF/EA FMS-Support Broker entity will operate in accordance with Section 3504 of the Internal Revenue Code and Rev. Proc. 70-6, as modified by REG137036-08 and Rev. Proc. 2013-39 and will provide both

financial management services (FMS) and information and assistance (I&A) services as administrative activities. The scope of FMS and I&A services provided by the VF/EA FMS-Support Broker entity are described in detail in subsequent sections.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

All waiver participants will receive information about using participant-directed services (PDS). As noted above, information regarding PDS will initially be provided to new waiver participants by Intake and Eligibility at DDS, and to current waiver participants by their waiver Service Coordinator. For all waiver participants, the waiver Service Coordinator documents the participant's needs and the choice of service delivery model in the person-centered ISP. Waiver Service Coordinators will also advise participants of their opportunity to change their method of waiver service delivery at any time and reassess the person's needs by facilitating a meeting with the interdisciplinary team. Waiver Service Coordinators will also re-introduce and provide information about PDS to waiver participants and document the participant's decision as to whether or not to use PDS each time the person-centered ISP is updated if the waiver participant is not already enrolled in the My Life My Way program.

With the support of an expert PDS consultant, DDS has developed materials to inform current and prospective waiver participants about the benefits and potential liabilities of using PDS. Orientation and training materials provided to participants and their representatives, as appropriate, include, but may not be limited to, details about self-directing their PDS, managing their PDS budget, using FMS and support broker services, being a common-law employer, and general Medicaid and non-Medicaid rights and responsibilities. These materials will be distributed to the Intake and Eligibility Unit at DDS and to all waiver Service Coordinators as part of their PDS training and will be made available on the DDS website. This information will be shared with all waiver participants upon enrolling in the IFS waiver and during each person-centered ISP update if the participant is not already enrolled in the My Life My Way program. This information is written at a level that is easily understood using everyday common language to ensure accessibility and is provided in multiple languages. The support broker is responsible for providing orientation and training to the participant/representative employer prior to employing a PDW.

Initial orientation and training are based upon a standard curriculum developed by DDS and includes the following:

• Review of the information and forms contained in both the Participant/Representative Employer Enrollment and PDW Employment and Individual-Directed Goods and Services Engagement Packets and how they should be completed;
• The role and responsibilities of the common law employer;
• The role and responsibilities of the VF/EA FMS Division and support broker;
• The process for receipt and processing PDW timesheets and payroll checks;
• The process for purchasing approved individual-directed goods and services from vendors, including submitting invoices for payment;
• Effective practices for recruiting, hiring, training, supervising, managing, and firing PDWs;
• The process for resolving issues and complaints; and
• Reviewing workplace safety issues, obtaining workers' compensation insurance coverage, and reporting PDW workplace injuries. In addition, the support broker is responsible for providing ongoing skills training to participants and working with the participant's Service Coordinator and VF/EA FMS Division to identify any participants who may need and/or desire additional employer skills training.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The participant may designate an authorized representative to exercise employer-related responsibilities. An authorized representative is a person who is the participant's substitute decision-maker, family member, or any other identified individual who willingly accepts responsibility for performing employer and budget management tasks that a participant is unable to perform him or herself. An authorized representative must evince a personal commitment to the participant, be willing to follow the participant's wishes and respect the participant's preferences while using sound judgment to act in the best interest of the participant. The authorized representative must be actively engaged in the participant's life and live in his or her community. An authorized representative also must execute a Designation of Authorized Representative form. A participant may have one of three (3) types of authorized representatives. These include: Pre-determined Representative - The participant has a legal guardian or another court-appointed representative in place at the time of enrollment and that individual will serve as the designated representative on the individual's behalf. Voluntary Representative – The participant requests that a representative serves on his/her behalf, or a support broker recommends that the participant designate a representative and the participant agrees. Representatives can include family members, friends or another person who is actively involved in the participant's life, chosen by the participant, and who shares authority with the participant for managing the participant's PDS budget. This authority must reflect the desires and preferences of the participant and may include being the common law employer of the participant's PDWs, when appropriate. The participant, with assistance from his/her support broker, as needed, selects his or her authorized representative. Mandated Representative – A person that the participant, with his/her support broker, chooses and that DDS requires the participant to have as his or her authorized representative. A mandated representative may be appointed when a participant has misspent funds or his/her function has deteriorated in such a way that the participant is no longer able to manage his/her individual budget. There may be other reasons that cause the DDS to require the participant to have a mandated representative as a condition of continued participation in the My Life My Way program. All types of authorized representatives receive no monetary compensation for being an authorized representative and may not serve as a paid PDW for the participant. All authorized representatives must meet the following requirements: i. Effectuate, as much as possible, the decision the waiver participant would make for him/herself.
ii. Accommodate the participant, to the extent necessary, so he/she can participate as fully as possible in all decisions. Accommodations include, but are not limited to, communication devices, interpreters, and physical assistance. iii. Give due consideration to all information including the recommendations of other interested and involved parties. iv. Embody the guiding principles of participant direction. v. Waiver participants and authorized representatives are responsible for working collaboratively to ensure: 1. Waiver participants receive needed in-home supports from qualified PDWs, and 2. Services are provided in accordance with the guiding principles of participant direction and in accordance with federal and state Medicaid and program requirements and with the waiver participant's person-centered ISP and PDS budget. The following safeguards are in place to ensure that the representative is performing in accordance with all of the above requirements: Authorized representatives are required to complete and sign an Authorized Representative Designation Form, which includes, among many others, attestations that the representative will make decisions in the participant's best interest, has not been convicted of a felony, and will attend initial orientation and ongoing training as required by DDS. The performance of authorized representatives will be continually monitored by the participant's support broker and Service Coordinator, either of whom may alert DDS or its designee if there is a concern regarding whether the representative is acting in the participant's best interest. Participant-directed workers may also alert the participant's support broker or Service Coordinator with any concerns regarding a representative's performance.

FMS are provided to all waiver participants enrolled in the My Life My Way program by one, District-wide, qualified VF/EA FMS-Support Broker entity, selected through a competitive procurement process (RFP). The VF/EA FMS-Support Broker entity receives a per participant per day administrative fee for the VF/EA FMS administrative service provided that is established through the competitive procurement process. The selected vendor must apply the per participant per day fee consistently with each waiver participant/representative employer actively enrolled with the vendor. The VF/EA FMS-Support Broker entity receives a separate per participant per day administrative fee for the support broker service provided by the VF/EA FMS-Support Broker entity, established through the competitive procurement process. The selected vendor must apply the per participant per day fee consistently with each waiver participant/representative employer actively enrolled with the vendor. The VF/EA FMS-Support Broker entity receives a separate one-time set-up fee for enrolling the participant/representative employer with the VF/EA FMS-Support Broker entity. The one-time set-up fee is consistent for each waiver participant/representative employer. The VF/EA FMS-Support Broker entity

receives a separate one-time set-up fee for enrolling the PDW in the VF/EA FMS-Support Broker entity's PDW payroll system. The one-time set-up fee is consistent for each qualified PDW.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
In-Home Supports	☒	☒
Individual Directed Goods and Services	☐	☒
Individualized Day Supports	☒	☒
Respite	☒	☒
Companion Services	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☐ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

FMS are provided to all waiver participants enrolled in the My Life My Way program by one, District-wide, qualified VF/EA FMS-Support Broker entity, selected through a competitive procurement process (RFP).

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The VF/EA FMS-Support Broker entity receives a per participant per day administrative fee for the VF/EA FMS administrative service provided that is established through the competitive procurement process. The selected vendor must apply the per participant per day fee consistently with each waiver participant/representative employer actively enrolled with the vendor. The VF/EA FMS-Support Broker entity receives a separate per participant per day administrative fee for the support broker service provided by the VF/EA FMS-Support Broker entity, established through the competitive procurement process. The selected vendor must apply the per participant per day fee consistently with each waiver participant/representative employer actively enrolled with the vendor. The VF/EA FMS-Support Broker entity receives a separate one-time set-up fee for enrolling the participant/representative employer with the VF/EA FMS-Support Broker entity. The one-time set-up fee is consistent for each waiver participant/representative employer. The VF/EA FMS-Support Broker entity receives a separate one-time set-up fee for enrolling the PDW in the VF/EA FMS-Support Broker entity's PDW payroll system. The one-time set-up fee is consistent for each qualified PDW.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☒ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**
- ☒ **Process and pay invoices for goods and services approved in the service plan**
- ☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

Specify:

Additional functions/activities:

- ☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☐ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☐ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☒ **Other**

Specify:

Supports furnished when the participant is the employer of direct support workers: Assists participant in verifying support worker citizenship status Collects and processes timesheets of support workers Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance Other Specify: The VF/EA FMS/Support Broker entity will operate in accordance with §3504 of the Internal Revenue Code and Rev. Proc. 70-6, as modified by REG-137036-08 and Rev. Proc. 2013-39, as well as applicable federal and District labor, citizenship and immigration, and workers' compensation requirements. In addition, the entity will offer the following FMS:

• Obtaining federal and District approval to perform as a VF/EA (e.g., filing and submission of IRS Forms 2678, and 8821, and DC powers of attorney for income tax and unemployment tax filing and payments);

• Preparing and maintaining a DC-specific VF/EA FMS-Support Broker Policies and Procedures Manual that includes written policies, procedures and internal controls for all VF/EA FMS and Support Broker tasks and updating it as needed and at least annually;

• Staying up-to-date with all federal and state program, labor, employment tax and workers' compensation insurance requirements related to participant/representative employers, their PDWs, and VF/EA FMS;

• Developing a transition plan to allow for least disruption of services for waiver participants transitioning from traditional waiver services to PDS or back to traditional in-home supports, respite, IDS and companion waiver services;

• Developing a transition plan for when/if the VF/EA FMS – Support Broker entity changes to facilitate the transition process and in accordance with DHCF requirements;

• Receiving and disbursing Medicaid funds and monitoring any balances;

• Submitting claims for Medicaid reimbursement for in-home supports, IDS, respite, companion Services and individual-directed goods and services (IDGS) rendered;

• Submitting invoices to DDS for VF/EA FMS and Support Broker administrative fees;

• Providing customer service (i.e., toll free phone and TYY numbers, information in alternate formats, foreign language translation and ASL, tracking calls and complaints, conducting complaint resolution and satisfaction surveys (paper, web-based, phone)) per DDS requirements;

• Preparing and distributing Participant/Representative-Employer Enrollment Packets;

• Collecting and processing the completed forms, agreements and information requested in the Participant/Representative-Employer Enrollment Packets;

• Preparing and distributing the PDW Employment and Individual-directed Goods and Services Vendor Engagement Packets;

• Collecting and processing the completed forms, agreements and information requested in the PDW Employment and Individual-directed Goods and Services Vendor Engagement Packets;

• Supports furnished when the participant is the employer of direct support workers: Assists participant in verifying support worker citizenship status Collects and processes timesheets of support workers Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance Other Specify: The VF/EA FMS/Support Broker entity will operate in accordance with §3504 of the Internal Revenue Code and Rev. Proc. 70-6, as modified by REG-137036-08 and Rev. Proc. 2013-39, as well as applicable federal and District labor, citizenship and immigration, and workers' compensation requirements. In addition, the entity will offer the following

FMS: • Obtaining federal and District approval to perform as a VF/EA (e.g., filing and submission of IRS Forms 2678, and 8821, and DC powers of attorney for income tax and unemployment tax filing and payments);

• Preparing and maintaining a DC-specific VF/EA FMS-Support Broker Policies and Procedures Manual that includes written policies, procedures and internal controls for all VF/EA FMS and Support Broker tasks and updating it as needed and at least annually;

• Staying up-to-date with all federal and state program, labor, employment tax and workers' compensation insurance requirements related to participant/representative employers, their PDWs, and VF/EA FMS;

• Developing a transition plan to allow for least disruption of services for waiver participants transitioning from traditional In-Home supports, IDS and Companion waiver services to PDS or back to traditional In-Home supports, IDS and Companion waiver services;

• Developing a transition plan for when/if the VF/EA FMS – Support Broker entity changes to facilitate the transition process and in accordance with DHCF requirements;

• Receiving and disbursing Medicaid funds and monitoring any balances;

• Submitting claims for Medicaid reimbursement for In-Home supports and individual-directed goods and services rendered;

• Submitting invoices to DDS for VF/EA FMS and Support Broker administrative fees;

• Providing customer service (i.e., toll free phone and TYY numbers, information in alternate formats, foreign language translation and ASL, tracking calls and complaints, conducting complaint resolution and satisfaction surveys (paper, web-based, phone)) per DDS requirements;

• Preparing and distributing Participant/Representative-Employer Enrollment Packets;

• Collecting and processing the completed forms, agreements and information requested in the Participant/Representative-Employer Enrollment Packets;

• Preparing and distributing the PDW Employment and Individual-directed Goods and Services Vendor Engagement Packets;

• Collecting and processing the completed forms, agreements and information requested in the PDW Employment and Individual-directed Goods and Services Vendor Engagement Packets;

• Enrolling waiver participant/representative employers with the VF/EA FMS-Support Broker entity;

• Enrolling PDWs in the VF/EA FMS-Support Broker entity's payroll system;

• Processing criminal background checks for PDW candidates and providing results to DDS, waiver participant/representative employers and PDW candidates;

• Reporting PDWs in the DC New Hire Reporting System;

• Assisting participant/representative employers with determining citizenship and legal alien status by processing the US CIS Form I-9;

• Collecting and processing PDWs' timesheets in accordance with a participant's person-centered ISP and PDS budget;

• Processing PDW payroll including paying wages in compliance with the DC Living Wage Act and

filing and paying federal and District of Columbia required taxes;

• Processing garnishments liens and levies against PDWs' wages;

• Processing end-of-year federal and state tax activities including IRS Forms W-2, FICA refunds, and DC tax reconciliations, as required;

• Receiving and processing invoices from individual-directed goods and services vendors for payment;

• Processing returned payments (i.e. payroll checks or payments to individual-directed goods and services providers) in accordance with the District's Unclaimed Property Law;

• Managing the receipt and renewal of workers' compensation insurance policies for waiver participant/representative-employers;

o Paying workers' compensation insurance premiums on behalf of the participant/representative employer;

o Providing wage information to the workers' compensation insurance carrier to determine workers' compensation insurance benefits, and

o Being the site for the annual workers' compensation insurance audit;

• Establishing and maintaining current and archived records and files in a confidential and secure manner and for required time period;

• Implementing and testing a disaster recovery plan for electronic data and files;

• Preparing and submitting DDS required reports; and

• Executing Medicaid provider agreements for PDWs and individual-directed goods and services vendors as authorized under a written agreement with the Medicaid agency and maintaining them on file.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

DDS will monitor and assess the readiness and ongoing performance of the VF/EA FMS-Support Broker entity through a number of monitoring activities. DDS will conduct a readiness review of the VF/EA FMS Support Broker entity prior to the contract being finalized and services being implemented. DDS will also conduct an annual VF/EA FMS-Supports Broker Entity Quality Assessment and Performance Review using the methods described earlier in Appendix A (5) and (6). The VF/EA FMS-Support Broker entity will be required to prepare and submit monthly utilization and expenditure reports to DDS as required. DDS's Office of Contracts and Procurement (OCP), in collaboration with the Health Care Delivery Management Administration's (HCDMA) Division of Quality and Health Outcomes (DQHO), will address other quality assurance related issues as they arise. DDS will conduct a participant/representative employer satisfaction survey within 60 days of the participant enrolling in the My Life My Way program, and on an annual basis thereafter. DDS will analyze the survey results and include them in the VF/EA FMS-Support Broker entity annual performance review. The VF/EA FMS-Support Broker entity will be required to develop an ongoing Quality Assurance Monitoring Plan, subject to DDS approval, that includes the following elements:

• Key indicators/measures of quality related to the provision of VF/EA FMS and support broker services;
• A description of how the VF/EA FMS-Support Broker entity plans to monitor these key indicators/measures;
• A description of how the VF/EA FMS-Support Broker entity shall develop, implement, and evaluate corrective actions or modifications to overall operations as necessary to address quality concerns;
• A description of the staffing resources responsible for the quality assurance plan and quality assurance activities;
• Samples of all reports related to quality assurance and performance monitoring, along with descriptions of their use and who is responsible for reviewing them; and
• A description of how the quality assurance plan shall help DDS meet all quality assurances as described in its IFS waiver.

Based on survey results from the Participant/Representative Employer Satisfaction Survey provided by DDS, the VF/EA FMS-Support Broker entity shall prepare a corrective action plan to address the issues raised as applicable and incorporate issues into its quality assurance process and VF/EA FMS-Support Broker entity's policies, procedures and internal controls, as appropriate.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Service Coordination services facilitate coordination of all waiver services, including participant-directed services, provided to participants so that services are delivered in a well-coordinated, safe, timely and cost-efficient manner that addresses the participant's specific needs. Service Coordination services for all waiver participants are detailed in Appendix D. In addition to all responsibilities detailed in Appendix D, a participant's waiver Service Coordinator performs the following information and assistance tasks related to PDS:
• Conducts initial outreach and education on the My Life My Way program for waiver participants using standard outreach and PDS information materials and documents the participant's decision to use PDS or not and the reason for the decision.
• Re-introduces the My Life My Way program to waiver participants not enrolled in PDS and documents the participant's decision to use PDS or not and the reason for the decision each time the participant's person-centered ISP is updated using standard outreach and PDS information materials.
• Identifies waiver participants' desired outcomes for using PDS under a person-centered planning process.
• Assists participants who wish to enroll in the My Life My Way program to complete a DDS Consumer Inquiry Form and Participant Consent Form.
• Submits executed DDS Consumer Inquiry and Participant Consent Forms to the My Life My Way Program Coordinator for processing.
• Includes PDS in the participant's person-centered ISP and computes the participant's PDS monthly allocation amount.
• Provides copies of the participant's updated and approved person-centered ISP, risk mitigation plan and PDS monthly allocation amount to the participant and his/her representative, as appropriate, the waiver participant's support broker, and the My Life My Way Program Coordinator.
• Monitors participant/representative employer performance in using PDS in collaboration with the participant's support broker.
• Participates in the Remediation, Training and Termination process with the My Life My Way Program Coordinator, VF/EA FMS Division, support broker and other entities, as appropriate.
• Assesses participants' and representatives', as appropriate, receipt of and satisfaction with PDS in collaboration with the participant's support broker.
• Assesses participants' and representatives' receipt of and satisfaction with traditional services.
• Apprises participants of general Medicaid and non-Medicaid rights and responsibilities.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Emergency Response System (PERS)	☐
Assistive Technology Services	☐
Behavioral Supports	☐
Skilled Nursing	☐
In-Home Supports	☒
Individual Supported Employment	☐
Wellness Services	☐
Employment Readiness	☐
Personal Care Services	☐
Individual Directed Goods and Services	☒
Day Habilitation	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Speech, Hearing, and Language	☐
Parenting Supports	☐
Physical Therapy	☐
Individualized Day Supports	☒
Occupational Therapy	☐
Respite	☒
Group Supported Employment	☐
Education Supports	☐
Unpaid Family/Caregiver Training	☐
Companion Services	☒
Creative Arts Therapies	☐

☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

The Support Broker Division of the VF/EA FMS-Support Broker entity will furnish information and assistance (I&A) supports to waiver participants enrolled in the My Life My Way program and their representatives as appropriate. As detailed above, the I&A supports will be procured through a competitive bidding process (RFP) to secure one VF/EA FMS-Support Broker entity, which will serve all waiver participants enrolled in the My Life My Way program and their representatives, as appropriate, in the District. Furthermore, as detailed above, the VF/EA FMS-Support Broker entity will receive a consistent per participant per day fee for support broker services. A waiver participant's support broker furnishes the following I&A supports related to in-home supports and individual directed goods and services: • Provides initial orientation to waiver participants and their representatives, as appropriate, on using the My Life My Way program, self-directing their PDS and managing their PDS budget, using FMS and support broker services, being a common law employer, and general Medicaid and non-Medicaid rights and responsibilities.
• Provides initial skills training on using the My Life My Way program, self-directing their PDS, and managing their PDS budget, using FMS and support broker services, being a common law employer, and general Medicaid and non-Medicaid rights and responsibilities.
• Provides ongoing skills training on using the My Life My Way program, self-directing their PDS and managing their PDS budget, using FMS and support broker services, being a common law employer, and general Medicaid and non-Medicaid rights and responsibilities as needed.
• Assists waiver participant/representative employers in providing the information requested in and completing the forms and agreements included in the Participant/Representative-Employer Enrollment Packet and Participant-directed Worker (PDW) Employment and Individual-Directed Goods and Services Vendor Engagement Packet.
• Assists participant/representative employers in developing, implementing, monitoring effectiveness, and revising, as needed, emergency back-up and natural support plans and designated emergency back-up staff and natural supports.
• Assists waiver participants in designating an authorized representative, if needed and wanted, assessing effectiveness of the authorized representative, and selecting a new authorized representative, if necessary.
• Receives waiver participants' PDS monthly allocation amount from the waiver case manager to develop, with the waiver participant and his/her representative, as appropriate, his/her initial PDS budget and any updated budgets.
• Develops, with the waiver participant and his/her representative, as appropriate, the participant's PDS budget for approval from DDS or its designee.
• Updates, with the waiver participant and his/her representative, as appropriate, the waiver participant's PDS budget and submits the budget for approval from DDS or its designee.
• Develops with the participant and his/her representative, as appropriate, proposals to reallocate PDS budget funds from labor to individual-directed goods and services or vice versa and submits them for approval from DDS or its designee.
• Assists the participant and his/her representative, as appropriate, in tracking his/her PDS expenditures in accordance with the participant's PDS budget.
• Assists participants and representatives, as appropriate, in identifying and accessing PDS.
• Assists participants and representatives, as appropriate, in making decisions about purchasing individual directed goods and services.
• Assists participants and representatives, as appropriate, in resolving issues as they arise.
• Conducts periodic in-home visits and phone calls with participants to monitor that their PDS is being provided in accordance with the participant's individual service plan and PDS budget, their health and safety and to answer questions or concerns.
o The support broker will document their findings in each waiver participant's file at the VF/EA FMS-Support Broker entity.
o A copy of the findings will be provided to DDS or its designee and the participant's waiver case manager.
• Assesses waiver participants' and representatives' use of and satisfaction with PDS through conducting quarterly in-home visits and monthly telephone contacts with participants and representatives.
• Assesses effectiveness of participants authorized representative and suggests modification, as needed.
• Assesses effectiveness of participant/representative employer's emergency PDW backup plan and designated staff and suggests modifications, as needed.
• Assesses effectiveness of participant/representative employer's natural supports plan and delegated natural supports and suggests modifications, as needed.
• Assesses effectiveness of participant's risk mitigation plan related to the receipt of PDS and suggests modifications to the plan, as needed.
• Reports critical incidents as a mandatory reporter.
• Participates in the Remediation, Training and Termination process with DDS or its designee, waiver case manager,

VF/EA FMS Division, and other entities, as appropriate. As noted above, the VF/EA FMS-Support Broker entity performance is assessed prior to implementation through a readiness review conducted by DDS. Following implementation of services, DDS conducts an annual VF/EA FMS-Support Broker Entity Quality Assessment and Performance Review. All quality assessments and performance reviews of the VF/EA FMS-Support Broker entity include the I&A supports described above. DDS also conducts participant/representative employer satisfaction surveys within 60 days of enrollment in the My Life My Way program and annually thereafter. The surveys address satisfaction with the I&A services furnished by support brokers as described above.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Waiver participants have the option to transition from participant direction to the provider-managed service delivery model at any time. This is accomplished by the participant completing the Voluntary Participant Termination Notice and sending it to DDS or its designee for processing. DDS or its designee will then inform the participant's support broker and the service coordinator of the participant's decision. The waiver Service Coordinator will then guide the waiver participant through the transition process and be responsible for transitioning the waiver participant to the traditional model of service. The waiver Service Coordinator will ensure there is no break in service during the transition period and secure all necessary supports for the waiver participant.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

DDS will develop and implement remediation, training and termination protocol when required for participant/representative-employers who fail to comply with the terms of the Participant/Representative Employer (PRE) Agreement. Non-compliance with the PRE Agreement may be discovered by the VF/EA FMS-Support Broker entity, the waiver participant's support broker, the waiver participant's waiver case manager, or DDS staff. PREs will be allowed three (3) episodes of non-compliance in the first 12-month period of enrollment in the My Life My Way program (and every 12-month period thereafter). The third episode of non-compliance will necessitate the participant's termination from the My Life My Way program and a transition to traditional in-home supports services, IDS and Companion Services. "Traditional" in-home support services, IDS and Companion Services refer to those services provided by a provider agency. When a common law employer is first found to be out of compliance with the PRE Agreement, the following steps shall occur: A. DDS or its desginee will issue a notification of non-compliance to the PRE (and the assigned Support Broker) regarding the issue of non-compliance, which will: i. Identify the issue of non-compliance and request that the issue be corrected (if possible), and not repeated. ii. Detail requirements of the Participant-Directed Corrective Action Plan (PCAP). iii. Offer training and/or technical assistance. iv. Encourage the PRE to direct questions to the Support Broker, including the following: a. To request training or technical assistance, as needed. b. To request a copy of the PRE Agreement. c. To ask questions about the notification of non-compliance. d. To ask questions regarding how to correct the issue of non-compliance. e. To obtain assistance in preparing and submitting the PCAP. f. To designate a representative to perform as the PRE (or designate a new representative). v. Identify consequences of further non-compliance with the PRE Agreement. vi. Provide details on the participant's fair hearing and appeal rights regarding termination from the My Life My Way program, should three (3) episodes of non-compliance occur in the first 12-month period of enrollment in the My Life My Way program. B. The Support Broker will provide copies of the notification to the participant's IFS Waiver Service Coordinator, the VF/EA FMS-Support Broker entity, and other individuals, as necessary and appropriate. C. Within five (5) business days of issuing the notification of non-compliance, the assigned Support Broker will contact the PRE regarding the occurrence of non-compliance, and cover the following topics: i. Introductions, reason for the call and reference to the notification of non-compliance. ii. Identification and review of the issues of non-compliance and a request to have the PRE describe the problem(s) experienced related to the issues of non-compliance. iii. A request that the issue be corrected (if possible) and not repeated.

iv. Development of the PCAP. v. Review of the PRE Agreement to answer questions regarding compliance. vi. Provide an explanation of mandated training and/or technical assistance, which may include: a. Training and/or technical assistance conducted by the assigned Support Broker, b. Training and/or technical assistance conducted by the FMS Division of the VF/EA FMS-Support Broker entity in collaboration with the assigned Support Broker. vii. Identify the consequences should three (3) episodes of non-compliance occur in the first 12-month period of enrollment in the My Life My Way program (and every 12-month period thereafter), wherein DDS may terminate the PRE Agreement with the participant, terminating the participant from the My Life My Way program and transition him/her to traditional in-home support services. D. Within five (5) business days of the above-mentioned contact, the assigned Support Broker, with the participant and his/her representative, as applicable, will draft a written PCAP based on the conversation and decisions made regarding mandatory training and/or technical assistance, timelines for completion of mandatory training and/or technical assistance, and consequences of not receiving the mandated training and/or technical assistance. The participant and his/her representative, as applicable, must sign the PCAP upon completion. The Support Broker will provide copies of the signed PCAP to the participant's Service Coordinator, VF/EA FMS-Support Broker entity and other individuals, as necessary and appropriate. i. The Support Broker will be responsible for monitoring the PCAP. If the participant or his/her representative, as applicable, fails to implement the PCAP as agreed upon, this will be considered an episode of non-compliance which will be reported by the Support Broker to DDS or its designee. Second Episode of Non-Compliance: When a Participant/Representative-Employer is found to be out of compliance with the PRE Agreement for a second time, the following steps will occur: A. DDS or its designee will issue a second notification of non-compliance to the Participant/Representative-Employer (and the assigned Support Broker) regarding the second occurrence of noncompliance, which will: i. Identify the issue of non-compliance and request that the issue be corrected (if possible), and not repeated. ii. Detail requirements of the PCAP. iii. Offer training and/or technical assistance. iv. Instruct the Participant/Representative-Employer to direct questions to the assigned Support Broker, including the following: a. To request training or technical assistance, as needed. b. To request a copy of the PRE Agreement. c. To ask questions about the notification of non-compliance. d. To ask questions regarding how to correct the issue of non-compliance. e. To designate a representative to perform as the PRE (or designate a new representative). f. To obtain assistance in preparing and submitting the PCAP. v. Identify consequences of further non-compliance with the PRE Agreement. vi. Provide details on the participant's fair hearing and appeal rights regarding termination from the My Life My Way program, should three episodes of non-compliance occur in the first 12-month period of enrollment in the My Life My Way program (and every 12-month period thereafter). B. DDS will share a copy of the notification of non-compliance with the assigned Support Broker, who will provide copies of the notification to the participant's Service Coordinator, VF/EA

FMS-Support Broker entity, and other individuals, as necessary and appropriate. C. Within five (5) business days of issuing the notification of non-compliance, the assigned Support Broker will contact the PRE regarding the occurrence of non-compliance, and cover the following topics: i. Introductions, reason for the call and reference to the notification of non-compliance. ii. Identification and review of the issues of non-compliance and a request to have the PRE describe the problem(s) experienced related to the issues of non-compliance. iii. A request that the issue be corrected (if possible) and not repeated. iv. Development of the PCAP. v. Review of the PRE Agreement to answer questions regarding compliance. vi. Provide an explanation of mandated training and/or technical assistance, which may include: a. Training and/or technical assistance conducted by the assigned Support Broker, b. Training and/or technical assistance conducted by the FMS Division of the VF/EA FMS-Support Broker entity in collaboration with the assigned Support Broker. vii. Identify the consequences should a third episode of non-compliance occur in the first 12-month period of enrollment in the My Life My Way program, wherein DDS may terminate the PRE Agreement with the participant, terminating the participant from the My Life My Way program and transition to traditional in- home supports, respite, IDS and Companion services. D. Within five (5) business days of the above mentioned contact, the assigned Support Broker, with the participant and his/her representative, as applicable, will draft a written PCAP based on the conversation and decisions made regarding mandatory training and/or technical assistance, timelines for completion of mandatory training and/or technical assistance, and consequences of not receiving the mandated training and/or technical assistance. The participant and his/her representative, as applicable, must sign the PCAP upon completion. The Support Broker will provide copies of the signed PCAP to the participant's Service Coordinator, VF/EA FMS-Support Broker entity, and other individuals, as necessary and appropriate. i. The Support Broker will be responsible for monitoring the PCAP. If the participant or his/her representative, as applicable, fails to implement the PCAP as agreed upon, this will be considered an episode of non-compliance which will be reported by the Support Broker to DDS or its designee. Third Episode of Non-Compliance: When a PRE is found to be out of compliance with the Participant/Representative-Employer Agreement for a third time, following the participation and completion of mandatory training and/or technical assistance to remediate the issue via successful implementation of the PCAP, the following steps will occur: A. DDS or its designee will issue a notification of non-compliance to the PRE (and the assigned Support Broker) regarding the third and final episode of non-compliance, which will note that: i. The PRE has had a third episode of non-compliance. ii. DDS is terminating the PRE Agreement with the participant, per earlier notification. iii. The participant will transition to traditional in-home supports, IDS and companion services. a. The participant may ask for a fair hearing from the Office of Administrative Hearings or the Office of Health Care Ombudsman. If a request for a fair hearing is filed before termination from the My Life My Way program (i.e., within thirty (30) days of the date on the notice), the participant will continue to receive current services while the appeal is pending. B. The Support Broker will provide copies of the notification to the participant's IFS Waiver Service Coordinator, the VF/EA FMS-Support Broker entity, and other individuals, as necessary and appropriate. C. Within five (5) business days of issuing the notification of non-compliance, the assigned Support Broker will contact the participant regarding the third and final occurrence of non-compliance, and will cover the following topics: i. Introductions, reason for the call and reference to the first, second, and third notifications of non-compliance. ii. Review of consequences of non-compliance (i.e., three (3) episodes in one 12-month period). iii. Process for transitioning the participant to traditional In-Home support services with support from the assigned Service Coordinator. iv. Details on the participant's fair hearing and appeal rights regarding termination from the My Life My Way program. D. Within five (5) business days of the above mentioned contact, the Support Broker will initiate completion of the Participant Termination Notice, in accordance with the Participant Termination Notice Instructions.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		0
Year 2		0

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 3		30
Year 4		40
Year 5		50

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☒ **Hire staff common law employer**
☐ **Verify staff qualifications**
☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Each potential PDW completes and pays for the combined FBI and District of Columbia criminal background check. Completing and passing the combined criminal background check is a condition of employment as a PDW. The criminal background check will be facilitated by the VF/EA FMS entity. If a PDW does not pass the required criminal background check, the participant/representative employer and DDS are notifed.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Each potential PDW completes and pays for the combined FBI and District of Columbia criminal background check. Completing and passing the combined criminal background check is a condition of employment as a PDW. The criminal background check will be facilitated by the VF/EA FMS entity. If a PDW does not pass the required criminal background check, the participant/representative employer and DDS are notified.

- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to state limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [x] **Discharge staff from providing services (co-employer)**
- [x] **Other**

Specify:

Benefits to PDWs will include the payment of Medicare and Social Security taxes (FICA), federal and state unemployment insurance taxes, and workers compensation insurance coverage, as well as any other benefits specifically required by DC or federal law as of the effective date of these amendments.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the state's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The participant-directed services (PDS) budget is developed based on the following methodology: (1) A person-centered ISP is developed based on the results of a comprehensive assessment for long term care services and supports using a standard tool. The process for person-centered ISP development is the same for all waiver participants, regardless of the service model. (2) Then, the total assessed hours per week for PDCS is determined and converted to hours per month. (3) Then, total in-home support hours per month are multiplied by the traditional rate of payment for in-home supports services, IDS, respite and/or Companion Services. (4) The total amount computed in Item 3 is then reduced by a pre-determined percentage to reflect the administrative overhead amount in the traditional in-home supports rate. (5) The resultant amount represents the participant's PDS monthly allocation amount, which will be used to compute his/her PDS budget.

The participant's PDS budget is developed by the participant and his/her support broker by executing the following steps: (1) The PDS budget contains five (5) cost components: in-home supports, respite, individualized day supports, companion services, and labor and s. ,individual-directed goods and services (2) The participant will determine the wage rate paid to his/her PDW(s) based on the wage range prescribed by DDS, which shall be no less than the DC living wage and no more, including employment taxes and insurance amounts, than the current rate paid for traditional in-home supports, respite, IDS and companion services. (3) Individual-directed goods and services (IDGS) will be determined based on available funds remaining in the PDS budget after the In-Home supports budget amount is determined. This methodology will be used to determine PDS budgets for all waiver participants enrolled in the My Life My Way program. The waiver Service Coordinator is responsible for explaining the method used to develop the participant's PDS monthly allocation amount and sharing the amount with the participant during the person-centered ISP development process, and with the participant's support broker. Then, the waiver participant works with his/her support broker to determine how the PDS budget will be developed and used to best serve the participant's needs while maintaining his/her health and welfare. The participant's support broker submits the PDS budget to DDS or its designee, who must approve all in-home supports and individual-directed goods and services requested in the budget. Once approved, the PDS budget is provided to the VF/EA FMS-Support Broker entity, which must pay PDWs for approved in-home support, respite, IDS, and Companion services rendered and invoices from vendors for approved individual-directed goods and services (IDGS) in accordance with the PDS budget. Information about the PDS budgeting process will be made available to individuals who express an interest in PDS and those who choose to enroll in the My Life My Way program through the outreach and training materials provided to them and will be available to the public on the DDS website.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

As detailed above, the service coordinator informs the participant of his/her PDS monthly allocation amount during the person-centered ISP development process. After discussing the monthly allocation amount with the participant and his/her representative, as appropriate, the waiver Service Coordinator provides the amount to the participant's support broker, who then works with the waiver participant to develop a detailed PDS budget based on the monthly allocation amount. If the participant's needs change at any time, the participant, with assistance from his/her support broker, may request an adjustment to his/her person-centered ISP and PDS budget by contacting his/her service coordinator, who will ensure that the participant receives a reassessment. DDS or its designee will notify the participant and his/her support broker of the approval or denial of the request for an adjustment through the issuance of a notification letter. If the participant disagrees with DDS or its designee determination, the participant may request a redetermination of the request. The participant also has the right to a fair hearing and appeals process as outlined in Appendix F.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

DDS will implement a number of safeguards to prevent the premature depletion of the PDS budget and address potential service delivery problems that may be associated with budget underutilization and the entities responsible for implementing these safeguards. (1) The VF/EA FMS Division will prepare and issue a monthly PDS budget report to PREs and their support brokers, waiver Service Coordinators, and DDS or its designee. This report will provide the PDS budget amount, services used, and expenditures incurred for the current month and year to date, as well as the remaining balance. The support broker will review this report with the PRE during his/her monthly call and will address any questions. (2) The VF/EA FMS Division will monitor in-home supports utilization by pay period and notify the PRE, his/her support broker, the waiver service cooridnator and DDS or designee in writing of any overage or underutilization of in-home supports, respite, IDS and Companion services. The support broker will then review the situation with the PRE and will address any questions. If there is an overage of in-home supports use, the VF/EA FMS Division will collect the amount of the overage from the PRE. An overage of In-Home supports, respite, IDS, and companion services use will also activate the Participant Remediation, Training and Termination process detailed above, which will require the PRE to prepare a Corrective Action Plan with assistance from his/her support broker that will detail how the PRE will remedy the situation in the future, and the receipt of additional training as needed. The VF/EA FMS Division will identify episodes of significant in-home supports, respite, IDS and companion services underutilization by notifying the PRE, his/her support broker, waiver Service Coordinator, and DDS or its designee in writing. The PRE will then address the issue with his/her support broker and develop a Corrective Action Plan as necessary to remedy the situation in the future and receive additional training as needed.

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 IFS 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 IFS 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 IFS waiver-funded service authorized on the participant's ISP, (4) the participant is denied his or her choice of qualified IFS 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 IFS 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**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

In addition to the right to request a fair hearing with the Office of Administrative Hearings (OAH), DDS operates an internal administrative grievance/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 filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDS' policy, "DDA Internal Problem Resolution Formal Complaints System Policy"", and cross referenced procedures apply to every individual who is eligible for and receiving services from DDA and the DDA service and outlines the method for individuals 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.

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 Director of Quality Assurance and Performance Management Administration (QAPMA) and the Mortality Review Coordinator assess the circumstances around the death and determines 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 a follow-up regarding services or unmet needs by telephone or email within two (2) business days of acceptance by the IRC of an of a 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 (3) three business days of assignment or by 5 p.m. the day following a weekend or holiday, unless waived by the supervisory investigator.
on-site visit within seventy two (72) hours of being accepted by the IRC.

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 provider 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 a 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 Director of the Quality Management Division 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) Deputy 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 every six months 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 person-centered and trauma informed, 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 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 individual and the function of the behaviors as described in the Behavior Support Policy and Procedure.

Methods for detecting unauthorized use, overuse 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 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 the Quality Assurance and Performance Management Administration (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.
The Quality Assurance and Performance Management Administration (QAPMA) 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, the Quality Assurance and Performance Management Administration (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 Director of 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) Deputy 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 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 ok 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 conducted 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 (RCRC0, 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 Management Division 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 QMD 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 data are 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 DDS'™ incident management system. DHCF's Long Term Care Division Unit 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 DHCF'™s ability to identify systemic issues or trends, DHCF uses all reports received and on a quarterly basis performs a comparison analysis. Based on this analysis, DHCF prepares a quarterly report which includes trends, findings and recommendations. This report is submitted to DHCF on a quarterly basis.

Additionally, DHCF, Long Term Care Administration 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 review 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 online 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)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

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)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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).

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

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, 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/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:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

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 Management Division.

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 make a recommendation to the responsible DDS unit to enter an incident or issue based on current issue and incident assignment procedures. If the committee suspects there is a pattern, the IRC Facilitator or designee will research the concern and report to the Director of the Quality Management Division. For each quarter, the Quality Management Division Director designates a person to prepare a summary report for the committee to review, analyze and make recommendations regarding medication errors as part of the 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 QAPMA.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
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 ISPs received fromDDS with a confidence interval 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**

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

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.1.b.PM.1. Percentage of MRC death investigations completed within 45 business days from the submission of the complete record, as outlined in the DDS mortality reporting procedure. Number of death investigations completed within 45 business days of submission of the complete record (numerator)/ Number of death investigations due to the MRC that quarter (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:

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**

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.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.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	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(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 =
☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW.a.i.b.PM.5 Percentage of death investigations reviewed by the Mortality Review Committee within 45 business days of the receipts of the death investigation report N= Number of death incidents reviewed by MRC within 45 business days of the receipt of the completed investigation/D= Number of death investigations due to be reviewed 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 =
☐ **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.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**

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

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	**Frequency of data**	**Sampling Approach**

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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**
☐ **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.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 *(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 (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.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 (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.c.PM.4.Percentage of behavior Support Plans (BSP) approved by the RCRC

restrictive measures reviewed by the RCRC as outlined in DDS's RCRC Procedure. N=Number of BSPs with restrictive measures approved by RCRC as outlined in DDS's RCRC Procedure / D=Number of BSPs with restrictive measures approved by RCRC.

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 = 90% confidence interval (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:

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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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 §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

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.
Plan-Do-Check-Act 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 brings 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 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 three primary external monitoring entities that provide valuable information regarding DDS performance serving individual participants. Quality Trust (QT) advocacy agency University Legal Services (ULS) serves as the protection 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 receive 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 received DDS will continue to review the reports from DC Health and analyze the data of the reports, but will not assign issues/sanctions – unless persons are in immediate jeopardy. The

Quality Resource Unit and Health and 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 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 HCBS 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**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Other** 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 (DDS) 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 Quality Assurance and Performance Management Administration (QAPMA) reports quarterly to DHCF regarding DDS discovery and remediation with regards to the waiver assurances and sub-assurances. In addition, QAPMA has redesigned the incident management reporting system to analyze incidents and make recommendations for provider and systems improvement. QAPMA has designed the incident management reporting system to analyze incidents and make recommendations for provider and systems improvement as the need arises. QAPMA has designed its Continuous Quality Improvement (CQI) report to analyze individual and provider issues and make recommendations for systems improvement.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

While all individuals within the Department have responsibility for assuring quality, 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 ongoing basis.

On an annual basis, considering performance data and input from stakeholders and external monitors, DDA's Leadership evaluates program and operational performance, key performance indicators and the 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 One City 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. Pre-payment 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 IFS 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 IFS waiver. On a monthly basis, PI conducts ongoing audits of IFS 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 2016, and it can be found at:
https://www.whitehouse.gov/omb/circulars/a133_compliance_supplement_2016

To supplement the audit process, this waiver will require annual cost reports to be submitted by all providers of Day Habilitation, 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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
FA.a.1.a.PM.1.Percent of claims for IFS waiver services denied by MMIS, by reason for denial. Numerator: Number of IFS waiver claims denied, by reason of denial. Denominator: Number of claims submitted for reimbursement of IFS 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***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
FA.a.1.a.PM.4. Percentage 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 person-centered plan authorizations (numerator) / Number of claims reviewed during the quarter (denominator).

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.

Performance Measure:
FA.a.1.b.PM.1. Percentage of provider payment rates that are consistent with rate methodology approved in the approved waiver application (or subsequent amendment). Number of provider payment rates that are consistent with rate methodology approved in waiver application (numerator) / Number of claims reviewed during the quarter (denominator).

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%*
☐ ***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***

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

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

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 IFS 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:*

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 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).*

Provider payment rates are uniform for every provider. DHCF & DDS elicit public comments through the DC's rulemaking process. Information about payment rates is available to participants via publication of proposed & ratified rules & from their service coordinator. DDS is responsible for the rate development with oversight by DHCF. Rate information including public comment is available upon request, on DHCF website at http://dhcf.dc.gov and DDS website at http://dds.dc.gov. Rate structures are based on geographic market analysis in DC & surrounding jurisdictions. Additional details on the rate setting method & each rate are available at: https://dds.dc.gov/page/waiver-amendment-information

DC requests CMS authority to inflate clinical and wellness services based on any rate of increase to the DC living wage. DC requests CMS authority to automatically increase rates as necessary to account for any enacted DC or Federal legislation requiring a wage increase or that impose fees or taxes that may ultimately affect the cost of providing waiver services.

Rates established for the IFS Waiver are based on those established under the District's IDD Waiver and align with IDD waiver rates for all services covered under both waivers. A summary of the IDD waiver rate methodology and rate changes approved by CMS are included. The IFS waiver rates will be adjusted when the ICF rates are rebased.

For Day Habilitation & Employment Readiness, facility costs are based on the average price per square foot for typical commercial space in the DC area of $30-35/ sq ft. & provides $7,000 per 25 participants per month + utilities ($800), phones/cable/internet ($600) & maintenance ($2,000). Small Group day services (no more than 15 persons) reduces the facility expenses to account for the smaller size to $5,000 for space, $500 for utilities, $500 for phones/cable/internet & $1,500 for maintenance. The daily rate also includes: DSP wage at the living wage $16.10 for 1:4 staff person to waiver participants in Day Hab & 1:3 waiver participants in small group + overtime & time off calculations;. RN oversight for medication administration & health assessments per DC policy of 1:25 HCBS individuals for Day Hab & 1:15 for small group; Program Manager for DSP supervision at 1:25 for Day Hab & 1:15 for small group; QIDP for programming responsibilities at 1:25 for Day Hab & 1:15 in small group; 20.62% fringe benefit rate applied to reflect actual costs in DC; an indirect percentage of 25% for transportation, program supplies & quality assurance responsibilities required by DC policy; a general & administrative percentage of 13% applied based on the total costs of all services, based on reasonable comparison with other provider categories; & an 85% occupancy rate (based on 2015 utilization review) applied to the rate to account for hospitalization, LTC, & vacation time that is not billable to the waiver program in Day Hab & 80% for small group, based on expectations that the acuity of the waiver participants in that program will have a higher absence rate.

The rates will be inflated by the rate of increase to the DC Living Wage. The Day Habilitation Rate shall be reimbursed at $6.52 per 1/4 hour or $156.48 per day, & is reasonable as compared to the EPD HCBS waiver rate for ADHP as approved under the 1915(i) State Plan reimbursement rate for acuity 2 at $130.60 per day. Day Habilitation Small Group shall be reimbursed at $11.85 per 1/4 hour. Employment readiness service shall be reimbursed at $5.63 per 1/4 hour and does not include reimbursement for RN oversight. The rates have remained sufficient to maintain an adequate provider network. The methodology is scheduled for review in late 2020 following submission of provider costs reports & will be reevaluated at that time.

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. The DSP base for HR is raised to the Living Wage; the front-line supervisor hours for IDS increased to 75; Details for productivity factors, indirect & each rate methodology can be found at: https://dds.dc.gov/page/waiver-amendment-information.

The rate-setting methodology used for Medicaid services delivered through traditional agency-based model will remain the same for services that are participant-directed. Participants who elect to use PDS will determine hourly rate paid to their participant-directed workers within range set by DHCF, which falls between District's established living wage and the rate paid to PCAs delivering Waiver services through the agency-based model. The Vendor Fiscal/Employer Agent Financial Management Services (VF/EA FMS) - Support Broker entity will assist participants who elect to use PDS through provision of financial management and support broker services and will receive a PMPM payment for provision of these services. In addition to the PMPM payment, VF/EA FMS-Support Broker entity will receive one-time payment

for enrolling participant/representative employer into its employer database and a one-time payment for enrolling each participant-directed worker into its payroll system. Rates for all three (3) types of payment made to VF/EA FMS-Support Broker entity are set through contract negotiation process on annual basis and included in VF/EA FMS-Support Broker entity's contract with DHCF.

Each hourly rate follows the same methodology with variances in the base wage based on the qualification requirements of the DSP, aligned with the 2015 BLS data for Washington DC metropolitan area if appropriate, productivity assumptions & indirect requirements of the service. As an example, In-home Support reimbursement methodology is calculated using the living wage of $16.10, which will be effective July 2022 as the base, productivity factor of 1.10 for a billable hour of $15.60, an addition of 20.62% for employee-related taxes & benefits for a total staff cost of $19.59. An addition of 16% for indirect & 13% administrative overhead is added to the staff cost. The DSP rate will be inflated anytime there is an increase in LW Rate or by whatever the ICF/IID rates are increased for these hourly rates beginning with FY18.

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 & the same method of service delivery. To expand the number of qualified providers & increase access to this service the rate was set at $100.00 per hour for all services in this category and per the approved cost of living adjustments the rate was inflated. Future inflation increases are tied to any rate of increase to the DC LW the rate for FY22 is $111.07.
Family Training is currently $67.56 hourly and is compared to State Plan clinical therapies & counseling services. The Peer rate for both services is calculated using the base wage of $18.40 (BLS 2015 Social & Human Service Assistants median) + productivity factor of 1.3% + employee benefits factor of 22.62% for a total staff cost of $28.08. Program support & administrative overhead percentage of 23% is added for a final rate of $37.15. 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.

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:*

[Continued from a. Rate Determination Methods above]
Behavior Support services methodology and rates have been reviewed relative to the DC State Plan, DC Behavioral Health system, DC Early Intervention Program & MD DD waiver program & remain appropriate. Access to services is also sufficient.

Wellness Services/ Fitness; Nutrition; Bereavement Counseling & Massage Therapy were reviewed & adjusted based on comparisons to a variety of competitive DC sources to ensure geographic market equity.
The Daily Respite rate under the IDD waiver was inflated in FY17 for associated costs by the CPI to a rate of $404.10 and a review of the methodology in FY17 confirmed that all assumptions remained the same. The hourly rate was inflated in FY17 by the CPI to $47.21 per day.

Assistive Technology (AT) is capped at $10,000 for the 5 year waiver period based upon a review of other state waivers who offer this service. Costs for AT purchases & maintenance will be comparable with costs in the DC Vocational Rehabilitation program, as well as past experience with services like Personal Emergency Response Systems.

One Time Transitional Services rate for this service is set as up to $5,000 to match Community Transition, the DC EPD HCBS waiver equivalent service, and the rate through the Money Follows the Person Demonstration project.

Skilled Nursing & Personal Care are extended State Plan services and match the State Plan rates.

Companion services match the State Plan rate for Personal Care. The rate for meals for people who live independently or with families and attend Day Habilitation or IDS is based upon actual cost of services from local vendors & then inflated using the CPI to a rate of $7.71 per meal for FY20.

The rates for Creative Arts Therapies were based upon 2015 market research (available upon request) that compared the District's rates with state plan rates for seniors, rates for therapies offered by the DC Department of Behavioral Health & private rate. The rates were adjusted by the CPI to a rate of $77.74 for FY18.

Dental rates are established by DHCF based on an average of all procedure codes.

Education Supports rate methodology was determined by comparing the education programs cost in the DC Vocational Rehabilitation program and takes into account the costs of classes at universities in the District.

b. Flow of Billings.
All provider billings flow directly from providers to the State's claims payment system. The District Medicaid Management Information System (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 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 as well as 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. Xerox 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 IFS 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 IFS 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 IFS 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.

The District will be paying supplemental payments to DSPs starting FY2023 and as necessary annually to alleviate the workforce shortage. The District will make an annual evaluation of the supplemental payment to determine if the result of the supplemental payment warrants an increase in the base wage of the DSPs used in the rate calculation to maintain sustainability.

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 §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- [x] ***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:*
Do not complete this item.

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		20597.10	20597.10	305370.64	5060.26	310430.90	289833.80
2		41194.20	41194.20	298804.88	6990.12	305795.00	264600.80
3		61791.30	61791.30	292239.13	8919.98	301159.11	239367.81
4		82388.40	82388.40	285673.38	10849.84	296523.22	214134.82
5		102985.50	102985.50	279107.63	12779.69	291887.32	188901.82

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	30	30
Year 2	60	60

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 3	90	90
Year 4	120	120
Year 5	150	150

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 District based the estimated average length of stay for WY1 of the IFS waiver on the average length of stay estimate for the corresponding year in the IDD waiver. The IDD waiver estimate was determined by dividing the total unduplicated participants by the total days of waiver coverage for each prior waiver year. The estimate for the remaining IDD waiver years was based on a trend analysis of historical data from CMS-372 reports.

The estimated average length of stay for WY2 - WY5 of the IFS waiver were held steady at the same number of days estimated for WY1. The District will make subsequent amendments to the estimated average length of stay as necessary following WY1 of the IFS waiver, based on actual data on IFS waiver participant enrollment and utilization.

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 IFS waiver by trending historic utilization in the IDD waiver forward. Specifically, the District used the historic data from IDD waiver CMS-372 reports and – for waiver years more recent than the most recently submitted CMS-372 report for the IDD waiver – 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 IDD waiver 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 IFS waiver services not included under the IDD waiver, and other services 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 IDD waiver user data from older years when there was no recent utilization.

Average Units per User
In general, the District estimated the Average Units per User for each service for each year of the IFS waiver by trending historic utilization in the IDD waiver forward. Specifically, the District used the historic utilization data from IDD waiver CMS-372 reports and – for waiver years more recent than the most recently submitted CMS-372 report for the IDD waiver – 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 days, services with service limitations were limited by the maximum allowable, etc.

For IFS waiver services not included under the IDD waiver, and other services 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 services not included under the IDD waiver, this was based on utilization of current services seen as close substitutes. For others, we used older IDD waiver utilization data when there was no recent utilization.

Average Cost per Unit
For the first year of the IFS waiver, 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. In many cases, that is simply an inflationary increase to the current rate for that service under the IDD waiver. For waiver year 2 through waiver year 5, the rates are inflated 2.6% annually, based on the estimate of the consumer price index from the District of Columbia Government's Office of Revenue Analysis.

Grand Total Cost
For each service for each year of the waiver, 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 waiver 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 waiver. For each year of the waiver, we add the total cost for all of the services to get the Grand Total Cost of the waiver for that year.

Factor D
The estimate of Factor D for each waiver year is derived by dividing the Grand Total Cost (described above) by the Total Unduplicated Participants for that year from Appendix J-2-a. There is no particular growth rate applied

to Factor D. 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, and the 2.6% inflation based on the consumer price index, applied to the Average Cost per Unit and the growth in unduplicated participants.

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:*

The estimate of Factor D' was based on the recent historical growth rate and trends in the IDD waiver. Specifically, the list of IFS waiver services was used to pull actual claim line item detail for the IDD waiver. This list was checked for inclusion in WY11 and WY12 of the IDD waiver at the line item level, procedure code, and modifier combination. Once confirmed, the associated reimbursement amount was categorized as a Factor D cost. The remaining claim detail costs for that claim's underlying member ID for the same time period was categorized as Factor D'. The projected growth rate of Factor D' in WY1 - WY5 is driven by the underlying projected growth rate of unduplicated participants (30pa).

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:*

The Factor G estimate for IFS waiver WY1 - WY5 was derived by trending historical user and claim data from the first two years of the IDD waiver renewal approved FY17, which differs from the Factor G estimates included in the IDD waiver renewal application. Factor G users for the IDD waiver declined in the first two years of the waiver renewal period by slightly over 2%. To derive Factor G user estimates for the IFS waiver, the District applied a trend, which reasonably projected a continued decline in users. The historical IDD waiver data showed that the average claim per user also declined over the first two years of the renewal period, due to a total claims decline in the absolute. To derive Factor G claims estimates for the IFS waiver, the District applied an average rather than a trend because the usage patterns are not likely to decline in the same way. The average cost per claim was then increased by inflation, as this is unlikely to decline or remain static under the same waiver dynamics.

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:*

The IFS waiver Factor G' estimates are based on the Factor G' estimates used for the District's approved IDD waiver. The IDD waiver Factor G' estimates approved in FY17 were derived by multiplying the 2.7% growth rate based on the 2017 Market Basket increase for Nursing Facilities by the Factor G' estimate in the FY16 IDD waiver year and then increased the amount annually by the same rate for IDD waiver renewal period years 1-5.

More specifically, IFS waiver WY1 - WY5 Factor G' estimates were derived by trending historical data from the first two years of the IDD waiver renewal approved FY17, which differs from the Factor G' estimates included in the IDD waiver renewal application. The actual data for the first two years of the IDD waiver renewal period showed a negative trend for users, units, and average claim per user for over a third of the services making up Factor G'. The Factor G' estimate for the IFS waiver was derived by averaging the first two years of the actual IDD waiver data. The IDD waiver data also had a few services that went from 1 user to zero users during the first two years of the renewal period. For the IFS waiver Factor G' estimate, zero utilization was assumed for these services. As a result, while the estimate for the IFS waiver Factor G' is based on recent historical data for the IDD waiver, there is a smoothing effect in the projection to account for the declining trends in utilization for the first two years of the IDD waiver renewal.

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	
Education Supports	
Employment Readiness	
Group Supported Employment	
Respite	
Personal Care Services	
Skilled Nursing	
Assistive Technology Services	
Behavioral Supports	
Companion Services	
Creative Arts Therapies	
In-Home Supports	
Individual Directed Goods and Services	
Individual Supported Employment	
Individualized Day Supports	
Occupational Therapy	
Parenting Supports	
Personal Emergency Response System (PERS)	
Physical Therapy	
Speech, Hearing, and Language	
Unpaid Family/Caregiver Training	
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:						300469.06
Day Habilitation - Individual	15 minutes	4	2526.58	6.08	61446.43	
Day Habilitation 1:1	15 minutes	2	1746.89	11.31	39514.65	
Day Habilitation - Small Group	15 minutes	10	2193.00	9.01	197589.30	
Day Habilitation w/ Meals (1:4 meal including	1 day	3	49.00	7.89	1159.83	
GRAND TOTAL:						
Total Estimated Unduplicated Participants:						30
Factor D (Divide total by number of participants):						
Average Length of Stay on the Waiver:					352	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
preparation/packaged)						
Day Habilitation w/ Meals (delivered by third party vendor)	1 day	3	46.67	5.42	758.85	
Education Supports Total:						5000.00
Education Supports	class	1	4.00	1250.00	5000.00	
Employment Readiness Total:						159532.79
Employment Readiness	15 minutes	14	2125.97	5.36	159532.79	
Group Supported Employment Total:						5880.62
Group Supported Employment - Job Training & Supports Professional	15 minutes	1	310.50	3.46	1074.33	
Group Supported Employment - Job Training & Supports Professional Extended	15 minutes	1	310.50	3.46	1074.33	
Group Supported Employment - Job Training & Supports Paraprofessional	15 minutes	1	310.50	3.46	1074.33	
Group Supported Employment - Job Training & Supports Paraprofessional Extended	15 minutes	1	310.50	3.46	1074.33	
Group Supported Employment - Long Term Follow Along Professional	15 minutes	1	114.40	3.46	395.82	
Group Supported Employment - Long Term Follow Along Professional Extended	15 minutes	1	114.40	3.46	395.82	
Group Supported Employment - Long Term Follow Along Paraprofessional	15 minutes	1	114.40	3.46	395.82	
Group Supported Employment - Long Term Follow Along Paraprofessional Extended	15 minutes	1	114.40	3.46	395.82	
Respite Total:						87132.44
Respite - Hourly & Extended	15 minutes	11	1036.78	6.03	68769.62	
Respite - Daily	1 day	3	14.00	437.21	18362.82	
Personal Care Services Total:						28444.00
Personal Care					28444.00	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	30
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services	15 minutes	5	1040.00	5.47		
Skilled Nursing Total:						85840.20
Skilled Nursing (Extended/RN)	15 minutes	2	2778.00	15.45	85840.20	
Assistive Technology Services Total:						2054.10
Assistive Technology - Assessment	Assessment	1	1.00	27.05	27.05	
Assistive Technology - Ongoing	15 minutes	1	1.00	27.05	27.05	
Assistive Technology - Goods & Services	1 unit	1	1.00	2000.00	2000.00	
Behavioral Supports Total:						70731.99
Behavioral Supports - Diagnostic Assessment	Flat rate	2	1.00	266.43	532.86	
Behavioral Supports - Professional Services	15 minutes	6	76.87	28.55	13167.83	
Behavioral Supports - Para-Professional Services	15 minutes	2	9.33	17.58	328.04	
Behavioral Supports - Non-Professional Services	15 minutes	2	4341.75	6.53	56703.26	
Companion Services Total:						7233.84
Companion Services	15 minutes	2	662.44	5.46	7233.84	
Creative Arts Therapies Total:						13509.90
CAT - Dance Therapy w/ EXT	15 minutes	1	170.00	26.49	4503.30	
CAT - Drama Therapy w/ EXT	15 minutes	1	170.00	26.49	4503.30	
CAT - Music Therapy w/ EXT	15 minutes	1	170.00	26.49	4503.30	
In-Home Supports Total:						1261505.37
In-Home Supports	15 minutes	27	7334.76	6.37	1261505.37	
Individual Directed Goods and Services Total:						
Individual Directed Goods and Services						
Individual Supported Employment Total:						43605.84
Supported Employment -	15 minutes				6750.39	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	30
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Training Paraprofessional		1	944.11	7.15		
Supported Employment - Training Professional	15 minutes	1	691.00	13.03	9003.73	
Supported Employment - Assessment Professional	15 minutes	1	78.50	13.03	1022.86	
Individual Supported Employment - Intake & Assessment Paraprofessional	15 minutes	1	1.00	7.15	7.15	
Individual Supported Employment - Job Placement Professional	15 minutes	1	405.00	13.03	5277.15	
Individual Supported Employment - Job Placement Professional Extended	15 minutes	1	405.00	13.03	5277.15	
Individual Supported Employment - Job Placement Paraprofessional	15 minutes	1	310.50	7.15	2220.08	
Individual Supported Employment - Job Placement Paraprofessional Extended	15 minutes	1	310.50	7.15	2220.08	
Individual Supported Employment - Job Training & Supports Professional Extended	15 minutes	1	405.00	13.03	5277.15	
Individual Supported Employment - Job Training & Supports Paraprofessional Extended	15 minutes	1	310.50	7.15	2220.08	
Individual Supported Employment - Long Term Follow Along Professional	15 minutes	1	151.40	7.15	1082.51	
Individual Supported Employment - Long Term Follow Along Professional Extended	15 minutes	1	151.40	7.15	1082.51	
Individual Supported Employment - Long Term Follow Along Paraprofessional	15 minutes	1	151.40	7.15	1082.51	
Individual Supported Employment - Long Term Follow Along Paraprofessional Extended	15 minutes	1	151.40	7.15	1082.51	
Individualized Day Supports Total:						32387.52
Individualized Day Support 1:1 (T2021 - U3)	15 minutes	4	707.48	6.46	18281.28	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	30
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individualized Day Support 1:2 (T2021 - HI)	15 minutes	1	848.67	9.37	7952.04	
Individualized Day Support - Meals (S9977 - U4)	1 day	5	156.00	7.89	6154.20	
Occupational Therapy Total:						329.54
Occupational Therapy	15 minutes	2	6.22	26.49	329.54	
Parenting Supports Total:						101.54
Parenting Supports - Professional Individual (1:1)	15 minutes	1	2.00	16.11	32.22	
Parenting Supports - Professional Small Group (1:2)	15 minutes	1	2.00	6.50	13.00	
Parenting Supports - Professional Small Group (1:3)	15 minutes	1	2.00	8.86	17.72	
Parenting Supports - Professional Small Group (1:4)	15 minutes	1	2.00	2.61	5.22	
Parenting Supports - Peer Individual (1:1)	15 minutes	1	2.00	8.86	17.72	
Parenting Supports - Peer Small Group (1:2)	15 minutes	1	2.00	2.61	5.22	
Parenting Supports - Peer Small Group (1:3)	15 minutes	1	2.00	2.61	5.22	
Parenting Supports - Peer Small Group (1:4)	15 minutes	1	2.00	2.61	5.22	
Personal Emergency Response System (PERS) Total:						86.46
PERS - Installation	flat rate	1	1.00	53.55	53.55	
PERS - Monthly Service	1 month	1	1.00	32.91	32.91	
Physical Therapy Total:						323.18
Physical Therapy	15 minutes	2	6.10	26.49	323.18	
Speech, Hearing, and Language Total:						4144.10
Speech, Hearing, Language (Individual)	15 minutes	2	62.22	26.49	3296.42	
Speech, Hearing, Language (Assessment)	assessment	2	16.00	26.49	847.68	
Unpaid Family/Caregiver Training Total:						1366.12

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	30
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Training - (Peer Supports) 1:1	15 minutes	1	8.00	8.86	70.88	
Family Training - (Peer Supports) 1:1 Extended	15 minutes	1	8.00	8.86	70.88	
Family Training - Caregiver Training	15 minutes	1	32.00	16.11	515.52	
Family Training Services	15 minutes	1	44.00	16.11	708.84	
Wellness Services Total:						
Wellness - Nutrition Counseling	15 minutes	5	31.45	17.58	2764.46	
Wellness - Fitness Trainer	15 minutes	7	208.00	19.86	28916.16	
Wellness - Bereavement Counseling	15 minutes	1	23.00	17.22	396.06	
Wellness - Massage Therapy	15 minutes	1	208.00	16.45	3421.60	
Wellness - Sexuality Education	15 minutes	2	10.67	20.54	438.32	
Wellness Services						
				GRAND TOTAL:		
				Total Estimated Unduplicated Participants:		30
				Factor D (Divide total by number of participants):		
				Average Length of Stay on the Waiver:	352	

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:						433223.49
Day Habilitation - Individual	15 minutes	8	2526.58	6.22	125722.62	
Day Habilitation 1:1	15 minutes	4	1746.89	11.58	80915.94	
Day Habilitation -					222655.29	
				GRAND TOTAL:		
				Total Estimated Unduplicated Participants:		60
				Factor D (Divide total by number of participants):		
				Average Length of Stay on the Waiver:	352	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Small Group	15 minutes	11	2193.00	9.23		
Day Habilitation w/ Meals (1:4 meal including preparation/packaged)	1 day	6	49.00	8.08	2375.52	
Day Habilitation w/ Meals (delivered by third party vendor)	1 day	6	46.67	5.55	1554.11	
Education Supports Total:						5120.00
Education Supports	class	1	4.00	1280.00	5120.00	
Employment Readiness Total:						244656.63
Employment Readiness	15 minutes	21	2125.97	5.48	244656.63	
Group Supported Employment Total:						6016.58
Group Supported Employment - Job Training & Supports Professional	15 minutes	1	310.50	3.54	1099.17	
Group Supported Employment - Job Training & Supports Professional Extended	15 minutes	1	310.50	3.54	1099.17	
Group Supported Employment - Job Training & Supports Paraprofessional	15 minutes	1	310.50	3.54	1099.17	
Group Supported Employment - Job Training & Supports Paraprofessional Extended	15 minutes	1	310.50	3.54	1099.17	
Group Supported Employment - Long Term Follow Along Professional	15 minutes	1	114.40	3.54	404.98	
Group Supported Employment - Long Term Follow Along Professional Extended	15 minutes	1	114.40	3.54	404.98	
Group Supported Employment - Long Term Follow Along Paraprofessional	15 minutes	1	114.40	3.54	404.98	
Group Supported Employment - Long Term Follow Along Paraprofessional Extended	15 minutes	1	114.40	3.54	404.98	
Respite Total:						178339.32
Respite - Hourly & Extended	15 minutes	22	1036.78	6.17	140732.52	
Respite - Daily					37606.80	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	60
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	1 day	6	14.00	447.70		
Personal Care Services Total:						64064.00
Personal Care Services	15 minutes	11	1040.00	5.60	64064.00	
Skilled Nursing Total:						175791.84
Skilled Nursing (Extended/RN)	15 minutes	4	2778.00	15.82	175791.84	
Assistive Technology Services Total:						2103.40
Assistive Technology - Assessment	Assessment	1	1.00	27.70	27.70	
Assistive Technology - Ongoing	15 minutes	1	1.00	27.70	27.70	
Assistive Technology - Goods & Services	1 unit	1	1.00	2048.00	2048.00	
Behavioral Supports Total:						144746.75
Behavioral Supports - Diagnostic Assessment	Flat rate	4	1.00	272.82	1091.28	
Behavioral Supports - Professional Services	15 minutes	12	76.87	29.24	26972.15	
Behavioral Supports - Para-Professional Services	15 minutes	4	9.33	18.00	671.76	
Behavioral Supports - Non-Professional Services	15 minutes	4	4341.75	6.68	116011.56	
Companion Services Total:						14812.16
Companion Services	15 minutes	4	662.44	5.59	14812.16	
Creative Arts Therapies Total:						13831.20
CAT - Dance Therapy w/ EXT	15 minutes	1	170.00	27.12	4610.40	
CAT - Drama Therapy w/ EXT	15 minutes	1	170.00	27.12	4610.40	
CAT - Music Therapy w/ EXT	15 minutes	1	170.00	27.12	4610.40	
In-Home Supports Total:						2582422.30
In-Home Supports	15 minutes	54	7334.76	6.52	2582422.30	
Individual Directed Goods and Services Total:						
Individual Directed Goods and Services						

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	60
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Supported Employment Total:						61846.56
Supported Employment - Training Paraprofessional	15 minutes	2	944.11	7.32	13821.77	
Supported Employment - Training Professional	15 minutes	2	691.00	13.35	18449.70	
Supported Employment - Assessment Professional	15 minutes	2	78.50	13.35	2095.95	
Individual Supported Employment - Intake & Assessment Paraprofessional	15 minutes	1	1.00	7.32	7.32	
Individual Supported Employment - Job Placement Professional	15 minutes	1	405.00	13.35	5406.75	
Individual Supported Employment - Job Placement Professional Extended	15 minutes	1	405.00	13.35	5406.75	
Individual Supported Employment - Job Placement Paraprofessional	15 minutes	1	310.50	7.32	2272.86	
Individual Supported Employment - Job Placement Paraprofessional Extended	15 minutes	1	310.50	7.32	2272.86	
Individual Supported Employment - Job Training & Supports Professional Extended	15 minutes	1	405.00	13.35	5406.75	
Individual Supported Employment - Job Training & Supports Paraprofessional Extended	15 minutes	1	310.50	7.32	2272.86	
Individual Supported Employment - Long Term Follow Along Professional	15 minutes	1	151.40	7.32	1108.25	
Individual Supported Employment - Long Term Follow Along Professional Extended	15 minutes	1	151.40	7.32	1108.25	
Individual Supported Employment - Long Term Follow Along Paraprofessional	15 minutes	1	151.40	7.32	1108.25	
Individual Supported Employment - Long Term Follow Along Paraprofessional	15 minutes	1	151.40	7.32	1108.25	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	60
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended						
Individualized Day Supports Total:						66367.40
Individualized Day Support 1:1 (T2021 - U3)	15 minutes	8	707.48	6.62	37468.14	
Individualized Day Support 1:2 (T2021 - HI)	15 minutes	2	848.67	9.60	16294.46	
Individualized Day Support - Meals (S9977 - U4)	1 day	10	156.00	8.08	12604.80	
Occupational Therapy Total:						674.75
Occupational Therapy	15 minutes	4	6.22	27.12	674.75	
Parenting Supports Total:						103.96
Parenting Supports - Professional Individual (1:1)	15 minutes	1	2.00	16.50	33.00	
Parenting Supports - Professional Small Group (1:2)	15 minutes	1	2.00	6.66	13.32	
Parenting Supports - Professional Small Group (1:3)	15 minutes	1	2.00	9.07	18.14	
Parenting Supports - Professional Small Group (1:4)	15 minutes	1	2.00	2.67	5.34	
Parenting Supports - Peer Individual (1:1)	15 minutes	1	2.00	9.07	18.14	
Parenting Supports - Peer Small Group (1:2)	15 minutes	1	2.00	2.67	5.34	
Parenting Supports - Peer Small Group (1:3)	15 minutes	1	2.00	2.67	5.34	
Parenting Supports - Peer Small Group (1:4)	15 minutes	1	2.00	2.67	5.34	
Personal Emergency Response System (PERS) Total:						88.53
PERS - Installation	flat rate	1	1.00	54.83	54.83	
PERS - Monthly Service	1 month	1	1.00	33.70	33.70	
Physical Therapy Total:						661.73
Physical Therapy	15 minutes	4	6.10	27.12	661.73	
Speech, Hearing, and Language Total:						8485.31
Speech, Hearing,					6749.63	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	60
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Language (Individual)	15 minutes	4	62.22	27.12		
Speech, Hearing, Language (Assessment)	assessment	4	16.00	27.12	1735.68	
Unpaid Family/Caregiver Training Total:						1927.12
Family Training - (Peer Supports) 1:1	15 minutes	1	8.00	9.07	72.56	
Family Training - (Peer Supports) 1:1 Extended	15 minutes	1	8.00	9.07	72.56	
Family Training - Caregiver Training	15 minutes	2	32.00	16.50	1056.00	
Family Training Services	15 minutes	1	44.00	16.50	726.00	
Wellness Services Total:						
Wellness - Nutrition Counseling	15 minutes	10	31.45	18.00	5661.00	
Wellness - Fitness Trainer	15 minutes	14	208.00	20.34	59230.08	
Wellness - Bereavement Counseling	15 minutes	2	23.00	17.63	810.98	
Wellness - Massage Therapy	15 minutes	2	208.00	16.85	7009.60	
Wellness - Sexuality Education	15 minutes	4	10.67	21.03	897.56	
Wellness Services						
			GRAND TOTAL:			
			Total Estimated Unduplicated Participants:			60
			Factor D (Divide total by number of participants):			
			Average Length of Stay on the Waiver:		352	

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:						572159.51
			GRAND TOTAL:			
			Total Estimated Unduplicated Participants:			90
			Factor D (Divide total by number of participants):			
			Average Length of Stay on the Waiver:		352	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation - Individual	15 minutes	12	2526.58	6.37	193131.78	
Day Habilitation 1:1	15 minutes	6	1746.89	11.86	124308.69	
Day Habilitation - Small Group	15 minutes	12	2193.00	9.45	248686.20	
Day Habilitation w/ Meals (1:4 meal including preparation/packaged)	1 day	9	49.00	8.27	3647.07	
Day Habilitation w/ Meals (delivered by third party vendor)	1 day	9	46.67	5.68	2385.77	
Education Supports Total:						5242.88
Education Supports	class	1	4.00	1310.72	5242.88	
Employment Readiness Total:						382334.44
Employment Readiness	15 minutes	32	2125.97	5.62	382334.44	
Group Supported Employment Total:						6152.55
Group Supported Employment - Job Training & Supports Professional	15 minutes	1	310.50	3.62	1124.01	
Group Supported Employment - Job Training & Supports Professional Extended	15 minutes	1	310.50	3.62	1124.01	
Group Supported Employment - Job Training & Supports Paraprofessional	15 minutes	1	310.50	3.62	1124.01	
Group Supported Employment - Job Training & Supports Paraprofessional Extended	15 minutes	1	310.50	3.62	1124.01	
Group Supported Employment - Long Term Follow Along Professional	15 minutes	1	114.40	3.62	414.13	
Group Supported Employment - Long Term Follow Along Professional Extended	15 minutes	1	114.40	3.62	414.13	
Group Supported Employment - Long Term Follow Along Paraprofessional	15 minutes	1	114.40	3.62	414.13	
Group Supported Employment - Long Term Follow Along Paraprofessional Extended	15 minutes	1	114.40	3.62	414.13	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	90
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						273995.54
Respite - Hourly & Extended	15 minutes	33	1036.78	6.32	216230.84	
Respite - Daily	1 day	9	14.00	458.45	57764.70	
Personal Care Services Total:						95347.20
Personal Care Services	15 minutes	16	1040.00	5.73	95347.20	
Skilled Nursing Total:						270021.60
Skilled Nursing (Extended/RN)	15 minutes	6	2778.00	16.20	270021.60	
Assistive Technology Services Total:						2153.87
Assistive Technology - Assessment	Assessment	1	1.00	28.36	28.36	
Assistive Technology - Ongoing	15 minutes	1	1.00	28.36	28.36	
Assistive Technology - Goods & Services	1 unit	1	1.00	2097.15	2097.15	
Behavioral Supports Total:						222320.13
Behavioral Supports - Diagnostic Assessment	Flat rate	6	1.00	279.37	1676.22	
Behavioral Supports - Professional Services	15 minutes	18	76.87	29.94	41426.78	
Behavioral Supports - Para-Professional Services	15 minutes	6	9.33	18.43	1031.71	
Behavioral Supports - Non-Professional Services	15 minutes	6	4341.75	6.84	178185.42	
Companion Services Total:						22774.69
Companion Services	15 minutes	6	662.44	5.73	22774.69	
Creative Arts Therapies Total:						14162.70
CAT - Dance Therapy w/ EXT	15 minutes	1	170.00	27.77	4720.90	
CAT - Drama Therapy w/ EXT	15 minutes	1	170.00	27.77	4720.90	
CAT - Music Therapy w/ EXT	15 minutes	1	170.00	27.77	4720.90	
In-Home Supports Total:						3968691.94
In-Home Supports	15 minutes	81	7334.76	6.68	3968691.94	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	90
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Directed Goods and Services Total:						
Individual Directed Goods and Services						
Individual Supported Employment Total:						80944.47
Supported Employment - Training Paraprofessional	15 minutes	3	944.11	7.50	21242.48	
Supported Employment - Training Professional	15 minutes	3	691.00	13.67	28337.91	
Supported Employment - Assessment Professional	15 minutes	3	78.50	13.67	3219.28	
Individual Supported Employment - Intake & Assessment Paraprofessional	15 minutes	1	1.00	7.50	7.50	
Individual Supported Employment - Job Placement Professional	15 minutes	1	405.00	13.67	5536.35	
Individual Supported Employment - Job Placement Professional Extended	15 minutes	1	405.00	13.67	5536.35	
Individual Supported Employment - Job Placement Paraprofessional	15 minutes	1	310.50	7.50	2328.75	
Individual Supported Employment - Job Placement Paraprofessional Extended	15 minutes	1	310.50	7.50	2328.75	
Individual Supported Employment - Job Training & Supports Professional Extended	15 minutes	1	405.00	13.67	5536.35	
Individual Supported Employment - Job Training & Supports Paraprofessional Extended	15 minutes	1	310.50	7.50	2328.75	
Individual Supported Employment - Long Term Follow Along Professional	15 minutes	1	151.40	7.50	1135.50	
Individual Supported Employment - Long Term Follow Along Professional Extended	15 minutes	1	151.40	7.50	1135.50	
Individual Supported Employment - Long Term Follow Along Paraprofessional	15 minutes	1	151.40	7.50	1135.50	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	90
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Supported Employment - Long Term Follow Along Paraprofessional Extended	15 minutes	1	151.40	7.50	1135.50	
Individualized Day Supports Total:						101939.65
Individualized Day Support 1:1 (T2021 - U3)	15 minutes	12	707.48	6.78	57560.57	
Individualized Day Support 1:2 (T2021 - HI)	15 minutes	3	848.67	9.83	25027.28	
Individualized Day Support - Meals (S9977 - U4)	1 day	15	156.00	8.27	19351.80	
Occupational Therapy Total:						1036.38
Occupational Therapy	15 minutes	6	6.22	27.77	1036.38	
Parenting Supports Total:						106.44
Parenting Supports - Professional Individual (1:1)	15 minutes	1	2.00	16.90	33.80	
Parenting Supports - Professional Small Group (1:2)	15 minutes	1	2.00	6.82	13.64	
Parenting Supports - Professional Small Group (1:3)	15 minutes	1	2.00	9.29	18.58	
Parenting Supports - Professional Small Group (1:4)	15 minutes	1	2.00	2.73	5.46	
Parenting Supports - Peer Individual (1:1)	15 minutes	1	2.00	9.29	18.58	
Parenting Supports - Peer Small Group (1:2)	15 minutes	1	2.00	2.73	5.46	
Parenting Supports - Peer Small Group (1:3)	15 minutes	1	2.00	2.73	5.46	
Parenting Supports - Peer Small Group (1:4)	15 minutes	1	2.00	2.73	5.46	
Personal Emergency Response System (PERS) Total:						90.66
PERS - Installation	flat rate	1	1.00	56.15	56.15	
PERS - Monthly Service	1 month	1	1.00	34.51	34.51	
Physical Therapy Total:						1016.38
Physical Therapy	15 minutes	6	6.10	27.77	1016.38	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	90
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech, Hearing, and Language Total:						13033.02
Speech, Hearing, Language (Individual)	15 minutes	6	62.22	27.77	10367.10	
Speech, Hearing, Language (Assessment)	assessment	6	16.00	27.77	2665.92	
Unpaid Family/Caregiver Training Total:						2514.64
Family Training - (Peer Supports) 1:1	15 minutes	1	8.00	9.29	74.32	
Family Training - (Peer Supports) 1:1 Extended	15 minutes	1	8.00	9.29	74.32	
Family Training - Caregiver Training	15 minutes	3	32.00	16.90	1622.40	
Family Training Services	15 minutes	1	44.00	16.90	743.60	
Wellness Services Total:						
Wellness - Nutrition Counseling	15 minutes	15	31.45	18.43	8694.35	
Wellness - Fitness Trainer	15 minutes	21	208.00	20.83	90985.44	
Wellness - Bereavement Counseling	15 minutes	3	23.00	18.06	1246.14	
Wellness - Massage Therapy	15 minutes	3	208.00	17.25	10764.00	
Wellness - Sexuality Education	15 minutes	6	10.67	21.53	1378.35	
Wellness Services						
				GRAND TOTAL:		
				Total Estimated Unduplicated Participants:		90
				Factor D (Divide total by number of participants):		
				Average Length of Stay on the Waiver:		352

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:						717556.86
Day Habilitation - Individual	15 minutes	16	2526.58	6.53	263977.08	
Day Habilitation 1:1	15 minutes	8	1746.89	12.14	169657.96	
Day Habilitation - Small Group	15 minutes	13	2193.00	9.67	275682.03	
Day Habilitation w/ Meals (1:4 meal including preparation/packaged)	1 day	12	49.00	8.47	4980.36	
Day Habilitation w/ Meals (delivered by third party vendor)	1 day	12	46.67	5.82	3259.43	
Education Supports Total:						5358.24
Education Supports	class	1	4.00	1339.56	5358.24	
Employment Readiness Total:						574543.39
Employment Readiness	15 minutes	47	2125.97	5.75	574543.39	
Group Supported Employment Total:						6288.52
Group Supported Employment - Job Training & Supports Professional	15 minutes	1	310.50	3.70	1148.85	
Group Supported Employment - Job Training & Supports Professional Extended	15 minutes	1	310.50	3.70	1148.85	
Group Supported Employment - Job Training & Supports Paraprofessional	15 minutes	1	310.50	3.70	1148.85	
Group Supported Employment - Job Training & Supports Paraprofessional Extended	15 minutes	1	310.50	3.70	1148.85	
Group Supported Employment - Long Term Follow Along Professional	15 minutes	1	114.40	3.70	423.28	
Group Supported Employment - Long Term Follow Along Professional Extended	15 minutes	1	114.40	3.70	423.28	
Group Supported Employment - Long Term Follow Along Paraprofessional	15 minutes	1	114.40	3.70	423.28	
Group Supported Employment - Long Term Follow Along	15 minutes	1	114.40	3.70	423.28	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	120
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Paraprofessional Extended						
Respite Total:						374018.13
Respite - Hourly & Extended	15 minutes	44	1036.78	6.47	295150.53	
Respite - Daily	1 day	12	14.00	469.45	78867.60	
Personal Care Services Total:						134076.80
Personal Care Services	15 minutes	22	1040.00	5.86	134076.80	
Skilled Nursing Total:						368696.16
Skilled Nursing (Extended/RN)	15 minutes	8	2778.00	16.59	368696.16	
Assistive Technology Services Total:						2201.25
Assistive Technology - Assessment	Assessment	1	1.00	28.98	28.98	
Assistive Technology - Ongoing	15 minutes	1	1.00	28.98	28.98	
Assistive Technology - Goods & Services	1 unit	1	1.00	2143.29	2143.29	
Behavioral Supports Total:						303747.20
Behavioral Supports - Diagnostic Assessment	Flat rate	8	1.00	286.08	2288.64	
Behavioral Supports - Professional Services	15 minutes	24	76.87	30.66	56564.02	
Behavioral Supports - Para-Professional Services	15 minutes	8	9.33	18.88	1409.20	
Behavioral Supports - Non-Professional Services	15 minutes	8	4341.75	7.01	243485.34	
Companion Services Total:						31108.18
Companion Services	15 minutes	8	662.44	5.87	31108.18	
Creative Arts Therapies Total:						14478.90
CAT - Dance Therapy w/ EXT	15 minutes	1	170.00	28.39	4826.30	
CAT - Drama Therapy w/ EXT	15 minutes	1	170.00	28.39	4826.30	
CAT - Music Therapy w/ EXT	15 minutes	1	170.00	28.39	4826.30	
In-Home Supports Total:						5418333.91
				GRAND TOTAL:		
				Total Estimated Unduplicated Participants:		120
				Factor D (Divide total by number of participants):		
				Average Length of Stay on the Waiver:		352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Supports	15 minutes	108	7334.76	6.84	5418333.91	
Individual Directed Goods and Services Total:						
Individual Directed Goods and Services						
Individual Supported Employment Total:						100819.68
Supported Employment - Training Paraprofessional	15 minutes	4	944.11	7.68	29003.06	
Supported Employment - Training Professional	15 minutes	4	691.00	13.99	38668.36	
Supported Employment - Assessment Professional	15 minutes	4	78.50	13.99	4392.86	
Individual Supported Employment - Intake & Assessment Paraprofessional	15 minutes	1	1.00	7.66	7.66	
Individual Supported Employment - Job Placement Professional	15 minutes	1	405.00	13.97	5657.85	
Individual Supported Employment - Job Placement Professional Extended	15 minutes	1	405.00	13.97	5657.85	
Individual Supported Employment - Job Placement Paraprofessional	15 minutes	1	310.50	7.66	2378.43	
Individual Supported Employment - Job Placement Paraprofessional Extended	15 minutes	1	310.50	7.66	2378.43	
Individual Supported Employment - Job Training & Supports Professional Extended	15 minutes	1	405.00	13.97	5657.85	
Individual Supported Employment - Job Training & Supports Paraprofessional Extended	15 minutes	1	310.50	7.66	2378.43	
Individual Supported Employment - Long Term Follow Along Professional	15 minutes	1	151.40	7.66	1159.72	
Individual Supported Employment - Long Term Follow Along Professional Extended	15 minutes	1	151.40	7.66	1159.72	
Individual Supported					1159.72	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	120
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment - Long Term Follow Along Paraprofessional	15 minutes	1	151.40	7.66		
Individual Supported Employment - Long Term Follow Along Paraprofessional Extended	15 minutes	1	151.40	7.66	1159.72	
Individualized Day Supports Total:						139138.21
Individualized Day Support 1:1 (T2021 - U3)	15 minutes	16	707.48	6.94	78558.58	
Individualized Day Support 1:2 (T2021 - HI)	15 minutes	4	848.67	10.07	34184.43	
Individualized Day Support - Meals (S9977 - U4)	1 day	20	156.00	8.46	26395.20	
Occupational Therapy Total:						1415.17
Occupational Therapy	15 minutes	8	6.22	28.44	1415.17	
Parenting Supports Total:						108.76
Parenting Supports - Professional Individual (1:1)	15 minutes	1	2.00	17.27	34.54	
Parenting Supports - Professional Small Group (1:2)	15 minutes	1	2.00	6.97	13.94	
Parenting Supports - Professional Small Group (1:3)	15 minutes	1	2.00	9.49	18.98	
Parenting Supports - Professional Small Group (1:4)	15 minutes	1	2.00	2.79	5.58	
Parenting Supports - Peer Individual (1:1)	15 minutes	1	2.00	9.49	18.98	
Parenting Supports - Peer Small Group (1:2)	15 minutes	1	2.00	2.79	5.58	
Parenting Supports - Peer Small Group (1:3)	15 minutes	1	2.00	2.79	5.58	
Parenting Supports - Peer Small Group (1:4)	15 minutes	1	2.00	2.79	5.58	
Personal Emergency Response System (PERS) Total:						92.64
PERS - Installation	flat rate	1	1.00	57.38	57.38	
PERS - Monthly Service	1 month	1	1.00	35.26	35.26	
Physical Therapy Total:						1387.87

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	120
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical Therapy	15 minutes	8	6.10	28.44	1387.87	
Speech, Hearing, and Language Total:						17796.61
Speech, Hearing, Language (Individual)	15 minutes	8	62.22	28.44	14156.29	
Speech, Hearing, Language (Assessment)	assessment	8	16.00	28.44	3640.32	
Unpaid Family/Caregiver Training Total:						3126.12
Family Training - (Peer Supports) 1:1	15 minutes	1	8.00	9.49	75.92	
Family Training - (Peer Supports) 1:1 Extended	15 minutes	1	8.00	9.49	75.92	
Family Training - Caregiver Training	15 minutes	4	32.00	17.30	2214.40	
Family Training Services	15 minutes	1	44.00	17.27	759.88	
Wellness Services Total:						
Wellness - Nutrition Counseling	15 minutes	20	31.45	18.88	11875.52	
Wellness - Fitness Trainer	15 minutes	28	208.00	21.33	124225.92	
Wellness - Bereavement Counseling	15 minutes	4	23.00	18.49	1701.08	
Wellness - Massage Therapy	15 minutes	4	208.00	17.67	14701.44	
Wellness - Sexuality Education	15 minutes	8	10.67	22.05	1882.19	
Wellness Services						
			GRAND TOTAL:			
			Total Estimated Unduplicated Participants:			120
			Factor D (Divide total by number of participants):			
			Average Length of Stay on the Waiver:			352

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:						869498.43
Day Habilitation - Individual	15 minutes	20	2526.58	6.68	337551.09	
Day Habilitation 1:1	15 minutes	10	1746.89	12.43	217138.43	
Day Habilitation - Small Group	15 minutes	14	2193.00	9.91	304256.82	
Day Habilitation w/ Meals (1:4 meal including preparation/packaged)	1 day	15	49.00	8.68	6379.80	
Day Habilitation w/ Meals (delivered by third party vendor)	1 day	15	46.67	5.96	4172.30	
Education Supports Total:						5470.76
Education Supports	class	1	4.00	1367.69	5470.76	
Employment Readiness Total:						889059.39
Employment Readiness	15 minutes	71	2125.97	5.89	889059.39	
Group Supported Employment Total:						6424.49
Group Supported Employment - Job Training & Supports Professional	15 minutes	1	310.50	3.78	1173.69	
Group Supported Employment - Job Training & Supports Professional Extended	15 minutes	1	310.50	3.78	1173.69	
Group Supported Employment - Job Training & Supports Paraprofessional	15 minutes	1	310.50	3.78	1173.69	
Group Supported Employment - Job Training & Supports Paraprofessional Extended	15 minutes	1	310.50	3.78	1173.69	
Group Supported Employment - Long Term Follow Along Professional	15 minutes	1	114.40	3.78	432.43	
Group Supported Employment - Long Term Follow Along Professional Extended	15 minutes	1	114.40	3.78	432.43	
Group Supported Employment - Long Term Follow Along Paraprofessional	15 minutes	1	114.40	3.78	432.43	
Group Supported Employment - Long Term Follow Along	15 minutes	1	114.40	3.78	432.43	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	150
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Paraprofessional Extended						
Respite Total:						479013.03
Respite - Hourly & Extended	15 minutes	55	1036.78	6.63	378061.83	
Respite - Daily	1 day	15	14.00	480.72	100951.20	
Personal Care Services Total:						167918.40
Personal Care Services	15 minutes	27	1040.00	5.98	167918.40	
Skilled Nursing Total:						471982.20
Skilled Nursing (Extended/RN)	15 minutes	10	2778.00	16.99	471982.20	
Assistive Technology Services Total:						2247.48
Assistive Technology - Assessment	Assessment	1	1.00	29.59	29.59	
Assistive Technology - Ongoing	15 minutes	1	1.00	29.59	29.59	
Assistive Technology - Goods & Services	1 unit	1	1.00	2188.30	2188.30	
Behavioral Supports Total:						388859.02
Behavioral Supports - Diagnostic Assessment	Flat rate	10	1.00	292.94	2929.40	
Behavioral Supports - Professional Services	15 minutes	30	76.87	31.39	72388.48	
Behavioral Supports - Para-Professional Services	15 minutes	10	9.33	19.33	1803.49	
Behavioral Supports - Non-Professional Services	15 minutes	10	4341.75	7.18	311737.65	
Companion Services Total:						39812.64
Companion Services	15 minutes	10	662.44	6.01	39812.64	
Creative Arts Therapies Total:						14779.80
CAT - Dance Therapy w/ EXT	15 minutes	1	170.00	28.98	4926.60	
CAT - Drama Therapy w/ EXT	15 minutes	1	170.00	28.98	4926.60	
CAT - Music Therapy w/ EXT	15 minutes	1	170.00	28.98	4926.60	
In-Home Supports Total:						6931348.20
				GRAND TOTAL:		
				Total Estimated Unduplicated Participants:		150
				Factor D (Divide total by number of participants):		
				Average Length of Stay on the Waiver:		352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Supports	15 minutes	135	7334.76	7.00	6931348.20	
Individual Directed Goods and Services Total:						
Individual Directed Goods and Services						
Individual Supported Employment Total:						121592.04
Supported Employment - Training Paraprofessional	15 minutes	5	944.11	7.86	37103.52	
Supported Employment - Training Professional	15 minutes	5	691.00	14.33	49510.15	
Supported Employment - Assessment Professional	15 minutes	5	78.50	14.33	5624.52	
Individual Supported Employment - Intake & Assessment Paraprofessional	15 minutes	1	1.00	7.82	7.82	
Individual Supported Employment - Job Placement Professional	15 minutes	1	405.00	14.26	5775.30	
Individual Supported Employment - Job Placement Professional Extended	15 minutes	1	405.00	14.26	5775.30	
Individual Supported Employment - Job Placement Paraprofessional	15 minutes	1	310.50	7.82	2428.11	
Individual Supported Employment - Job Placement Paraprofessional Extended	15 minutes	1	310.50	7.82	2428.11	
Individual Supported Employment - Job Training & Supports Professional Extended	15 minutes	1	405.00	14.26	5775.30	
Individual Supported Employment - Job Training & Supports Paraprofessional Extended	15 minutes	1	310.50	7.82	2428.11	
Individual Supported Employment - Long Term Follow Along Professional	15 minutes	1	151.40	7.82	1183.95	
Individual Supported Employment - Long Term Follow Along Professional Extended	15 minutes	1	151.40	7.82	1183.95	
Individual Supported					1183.95	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	150
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment - Long Term Follow Along Paraprofessional	15 minutes	1	151.40	7.82		
Individual Supported Employment - Long Term Follow Along Paraprofessional Extended	15 minutes	1	151.40	7.82	1183.95	
Individualized Day Supports Total:						178009.59
Individualized Day Support 1:1 (T2021 - U3)	15 minutes	20	707.48	7.11	100603.66	
Individualized Day Support 1:2 (T2021 - HI)	15 minutes	5	848.67	10.31	43748.94	
Individualized Day Support - Meals (S9977 - U4)	1 day	25	156.00	8.63	33657.00	
Occupational Therapy Total:						1811.26
Occupational Therapy	15 minutes	10	6.22	29.12	1811.26	
Parenting Supports Total:						111.04
Parenting Supports - Professional Individual (1:1)	15 minutes	1	2.00	17.63	35.26	
Parenting Supports - Professional Small Group (1:2)	15 minutes	1	2.00	7.11	14.22	
Parenting Supports - Professional Small Group (1:3)	15 minutes	1	2.00	9.69	19.38	
Parenting Supports - Professional Small Group (1:4)	15 minutes	1	2.00	2.85	5.70	
Parenting Supports - Peer Individual (1:1)	15 minutes	1	2.00	9.69	19.38	
Parenting Supports - Peer Small Group (1:2)	15 minutes	1	2.00	2.85	5.70	
Parenting Supports - Peer Small Group (1:3)	15 minutes	1	2.00	2.85	5.70	
Parenting Supports - Peer Small Group (1:4)	15 minutes	1	2.00	2.85	5.70	
Personal Emergency Response System (PERS) Total:						94.59
PERS - Installation	flat rate	1	1.00	58.59	58.59	
PERS - Monthly Service	1 month	1	1.00	36.00	36.00	
Physical Therapy Total:						1776.32

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	150
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical Therapy	15 minutes	10	6.10	29.12	1776.32	
Speech, Hearing, and Language Total:						22777.66
Speech, Hearing, Language (Individual)	15 minutes	10	62.22	29.12	18118.46	
Speech, Hearing, Language (Assessment)	assessment	10	16.00	29.12	4659.20	
Unpaid Family/Caregiver Training Total:						3765.96
Family Training - (Peer Supports) 1:1	15 minutes	1	8.00	9.69	77.52	
Family Training - (Peer Supports) 1:1 Extended	15 minutes	1	8.00	9.69	77.52	
Family Training - Caregiver Training	15 minutes	5	32.00	17.72	2835.20	
Family Training Services	15 minutes	1	44.00	17.63	775.72	
Wellness Services Total:						
Wellness - Nutrition Counseling	15 minutes	25	31.45	19.33	15198.21	
Wellness - Fitness Trainer	15 minutes	35	208.00	21.84	158995.20	
Wellness - Bereavement Counseling	15 minutes	5	23.00	18.93	2176.95	
Wellness - Massage Therapy	15 minutes	5	208.00	18.09	18813.60	
Wellness - Sexuality Education	15 minutes	10	10.67	22.58	2409.29	
Wellness Services						

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	150
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	352