

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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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 waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

### 1. Request Information

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**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:**

**Persons with Intellectual and Developmental Disabilities renewal waiver**

**C. Waiver Number:** DC.0307

**Original Base Waiver Number:** DC.0307.90R1

**D. Amendment Number:**

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

10/01/14

**Approved Effective Date of Waiver being Amended:** 11/20/12

### 2. Purpose(s) of Amendment

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

The amendment intends to make two types of changes to be effective in IDD HCBS Waiver Year 2, or upon approval by CMS. The first type of amendments or changes relate to the service name or service amount, duration, and scope. The second includes reimbursement methodology and rate changes. The service amendments include the following:

- 1) Art Therapies: Change name to Creative Art Therapies. Add ability to participate individually and/ or in a small group.
- 2) Behavioral Supports: Modify to a tiered service, utilizing low intensity behavioral supports, moderate behavioral supports, and high intensity behavioral supports, with corresponding caps on level of service, based on the person's assessed needs.
- 3) Day Habilitation: Add a nursing component to the service definition for the purpose of medication administration, and staff training and monitoring of the participants HCMPs.
- 4) Individualized Day: Modify requirements for DSP qualifications. Allow relatives to provide DSP services for the person.
- 5) Companion Service: Adds a new service.
- 6) Transportation Community Access: This service is not utilized and will be omitted because transportation is available through the Medicaid transportation provider.
- 7) Shared Living: This service is not utilized and will be omitted.
- 8) Skilled Nursing: Skilled nursing services will no longer be prohibited in a Supported Living setting.

- 9) Supported Employment: Amends provider qualifications by requiring that all Supported Employment providers become Rehabilitation Services Administration service providers within one year of approval of these amendments.
- 10) Supported Living: Add specialized rate authority when needed to provide intensive individualized staffing to support a person due to complex behaviors that may involve a serious risk to the health safety or well-being of the person or others, or when required by court order.
- 11) Supported Living: Modify service to allow skilled nursing to be provided in this setting.
- 12) Wellness: Modify requirements for fitness trainers to include people who have obtained a bachelor's level degree in physical education, health education, kinesiology, exercise science or recreational therapists. Add ability to participate individually and/ or with another person. Modify provider qualifications for bereavement counselors to ensure access to a larger group of qualified providers.
- 13) DHCF shall use spousal impoverishment rules to determine eligibility for the home and community-based waiver group, whereby a certain amount of the couples combined income and assets are protected for the spouse not receiving services under the HCBS waiver, to be effective in IDD HCBS Waiver Year 2, or upon approval by CMS; and
- 14) Correct the acronym of District of Columbia's Home and Community-Based Waiver for Individuals with Intellectual and Developmental Disabilities. The Waiver was previously abbreviated as ID/DD. Hereinafter, the waiver should be abbreviated as IDD; and
- 15) Amended and/or updated provider licensure and/or qualifications to ensure compliance with current District of Columbia standards and regulations.

The rate reimbursement and methodology changes include the following:

- 1) Provider rates for Residential Habilitation, Supported Living, In-Home Supports, Host Home, Behavioral Support Non-Professional and Respite services to increase to support the increase in the hourly wage rates for the Direct Support Professionals (DSPs) to be in compliance with the D.C. Living Wage Act of 2006 for FY 2014 and FY 2015.
- 2) The Day Habilitation services rate methodology to be changed to include nursing for staff training and oversight of Health Care Management Plans (HCMPs) at a ratio of 1:20, to be paid at the current nursing rate for a Registered Nurse of \$70,000
- 3) Host Home services rate to include a vacancy factor of 93% (1.07), to promote parity with all other residential services which also have a vacancy factor.
- 4) Supported Employment (all), Group Supported Employment, and Family Training services wage rates to be increased by the market basket rate for nursing homes for FY 2015 of 1.3%.
- 5) Based on clinical therapy rate research, the following rates are proposed: increase Behavior Paraprofessional from \$60 to \$65 per hour; increase OT, PT and Speech from \$65 to \$100 per hour; and, Nutrition from \$55 to \$60 per hour.
- 6) Art Therapies: Increase Art Therapy to \$75 per hour, and to introduce a group rate.
- 7) Fitness: Based on current market conditions, to reduce the rate from \$75 to \$50 per hour, and to introduce a group rate. Fitness: Based on current market conditions, to reduce the rate from \$75 to \$50 per hour, and to introduce a group rate. Supported Employment (all), Group Supported Employment, and Family Training services wage rates to be increased by the market basket rate for nursing homes for FY 2015 of 1.3%.
- 8) Individualized Day Supports rate to be reduced from \$24.44 per hour to \$21.79 per hour, based on market research and to promote parity with other individualized supports.
- 9) Adjustments were made to the rate methodology for Employment Readiness in areas where provider experience has reflected a need for changes to more accurately reflect reasonable cost allowances; and
- 10) Upon approval of the IDD HCBS waiver by CMS, DHCF and DDS intend to increase all rates in subsequent years based on requirements of the D.C. Living Wage Act of 2006 and the market basket indicators index for nursing homes to keep pace with inflation using appropriate Medicaid long-term care 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)

<input type="checkbox"/> Waiver Application	
<input type="checkbox"/> Appendix A – Waiver Administration and Operation	
<input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility	
<input checked="" type="checkbox"/> Appendix C – Participant Services	
<input type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	
<input type="checkbox"/> Appendix E – Participant Direction of Services	
<input type="checkbox"/> Appendix F – Participant Rights	
<input type="checkbox"/> Appendix G – Participant Safeguards	
<input type="checkbox"/> Appendix H	
<input type="checkbox"/> Appendix I – Financial Accountability	
<input checked="" type="checkbox"/> 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):  
**Persons with Intellectual and Developmental Disabilities renewal 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

**Original Base Waiver Number:** DC.0307

**Draft ID:** DC.02.03.01

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

Regular Waiver ▼

- E. Proposed Effective Date of Waiver being Amended:** 11/20/12  
**Approved Effective Date of Waiver being Amended:** 11/20/12

## 1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

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

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

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care: D.C. Official Code § 7-761.05(1)(a) requires DDS to [p]rovide services and supports to consumers in accordance with Chapter 13 of Title 7, which is the codification of D.C. Law 2-137, the “Mentally Retarded Citizens 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 through the admission and commitment process by petition to the Family Court for residential services and by application to DDS for non-residential services. See D.C. Official Code § 7-1301.03(2) and 7-1301.03 through 7-1303.06. In addition, eligibility for services is limited to individuals with an intellectual disability and other developmental disabilities under 29 DCMR § 1902.1(b), 51 DCR 10209 (Nov. 5, 2004).

## 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:

The §1915(b)(c) Transportation waiver is currently undergoing the District's legal sufficiency review before it is submitted to CMS for approval.

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

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

☐ **§1915(b)(2) (central broker)**

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

☒ **§1915(b)(4) (selective contracting/limit number of providers)**☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

Specify the program:

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

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

## 2. Brief Waiver Description

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**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.

The DC ID/DD 1915 (c) HCBS Waiver Program provides Medicaid participants who have specific intellectual and developmental disabilities the opportunity to receive as needed a range of health and health-related services and supports not available under the District of Columbia Medicaid State Plan. The goals of this comprehensive waiver program are to enable these Medicaid waiver participants to: 1) lead healthy, independent, and productive lives; 2) live, work, and fully participate in their communities to the fullest extent possible; 3) fully exercise their rights as residents, and 4) promote the integrity and well-being of their families. Further goals of this waiver are to provide these health and health-related services in a manner that: 5) meets each participant's needs, goals, and preferences in the most integrated, least restrictive setting possible; and 6) meets the widely accepted goals for quality health care of: safety, effectiveness, person-centeredness, timeliness, efficiency, and equity.

The objectives of this waiver are to ensure that:

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

The DC ID/DD HCBS Waiver renewal will continue nearly all existing services and supports for people currently enrolled in the District's ID/DD HCBS Waiver Program with an addition of a few new services. Assessment of intensity of support needs and urgent needs to access out-of-home residential services will be accomplished through administration of the DC Level of Need Assessment Risk Screening Tool and adherence to DDS waiting list policy and procedures, if applicable.

The DC Department of Health Care Finance (DHCF) is the Single State Medicaid Agency (SSMA) of the District of

Columbia. DHCF's responsibilities include the administration of the Medicaid program and this waiver. This authority can be found at D.C. Official Code §1-307.02 et seq. as authorized by Titles XIX and XXI of the Social Security Act. The Department on Disability Services (DDS), Developmental Disabilities Administration (DDA), is the operating agency for all services provided to persons with intellectual and developmental disabilities (ID/DD). The two agencies have a Memorandum of Agreement (MOA) to assure coordination, cooperation, and collaboration between DHCF and DDS in performing their respective duties in the provision of Home and Community Based Waiver Services (HCBS) for individuals with intellectual and developmental disabilities in the District.

DDS' Developmental Disabilities Administration (DDA), the Operating Agency, delivers service coordination as an administrative cost for all waiver participants. Service coordination includes Level of Care determination, development of the Individual Support Plan (ISP), support to access all necessary services and supports, crisis intervention support, and monitoring of the delivery of services and supports. All direct waiver services are delivered by private agencies enrolled as DC Medicaid providers with the DC Medicaid program, operated by DHCF. DDS/DDA approves service authorizations (SAs) following the completion of an ISP, submits the SA to DHCF for Medicaid Prior Authorization, coordinates the selection of service providers with waiver participants, conducts provider network quality assurance and improvement activities, and implements the Incident Management System and Human Rights System to ensure participant safeguards. In addition to its administrative oversight authority, DHCF operates and maintains the Financial Management components of this waiver program.

### 3. Components of the Waiver Request

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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

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- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- ☐ Not Applicable
- ☐ No
- ☒ Yes
- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
- ☒ No
- ☐ Yes

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

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

- ☐ **Limited Implementation of Participant-Direction.** A waiver of statewide 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

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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

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected



frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:  
The District (DHCF and DDS) held multiple public forums to gather input on what is currently working and what changes people are interested in seeing in the Home and Community Based Services Waiver for people with intellectual and developmental disabilities. In an effort to accommodate people receiving wavier services, these forums were held at various locations throughout the District and during various times during the week. Participants of these forums included people receiving waiver services, family members of people receiving services, advocates for people receiving services and service providers of people receiving services. As part of these public forums, the District provided an overview of waiver design and rules, which included a basic description of what the HCBS waiver is, waiver authority, and the services offered and paid for under the waiver.

In addition to holding public forums throughout the waiver development process, DDS posted a notice about the Medicaid waiver renewal on their website informing people and their families that “we want to hear from people who

are using the services in the waiver or who need services.” The webpage solicited specific information regarding:

What is working for you?

What could work better?

What services do you need?

What are your recommendations?

Unlike participation in the waiver forums, there was minimal input/response to these website questions. Nonetheless, the District took into consideration all feedback provided when designing the waiver.

The Waiver Amendment process also underwent its own public input process to review any significant changes to the waiver. The process was as follows:

The District (DHCF and DDS) published a Notice of Proposed Transition Plan and Amendments in the D.C. Register, posted copies of the Notice, proposed amendments and proposed transition plan on the DDS website, and made them all available upon request. The District also provided at least two opportunities to provide comments-- both in writing and through a public forum during which written and oral comments are accepted. Specifically, in addition to accepting written comments, the District hosted a public forum on all amendments and the transition plan, as well as a public forum specifically on the rate changes. The District also discussed and received oral comments on the amendments and the transition plan at meetings of the DDA Advisory Group and Project ACTION!, DC<sup>TM</sup>s advocacy group for people with intellectual and developmental disabilities. Finally, the District discussed the revised Performance Measures at a meeting of the DDS Quality Improvement Committee. The District took all public feedback into consideration when amending 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)

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

<b>Last Name:</b>	<input type="text" value="Iscandari"/>
<b>First Name:</b>	<input type="text" value="Yvonne"/>
<b>Title:</b>	<input type="text" value="Manager, Division of Long-Term Care"/>
<b>Agency:</b>	<input type="text" value="Department of health care Finance"/>
<b>Address:</b>	<input type="text" value="899 North Capitol Street, North East"/>
<b>Address 2:</b>	<input type="text" value="Suite 6109"/>
<b>City:</b>	<input type="text" value="Washington"/>
<b>State:</b>	<b>Dist. of Columbia</b>
<b>Zip:</b>	<input type="text" value="20002"/>

**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:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **Dist. of Columbia**

**Zip:**

**Phone:**  **Ext:**  ☐ **TTY**

**Fax:**

**E-mail:**

## 8. Authorizing Signature

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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.

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**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:**

<b>First Name:</b>	<input type="text" value="Claudia"/>		
<b>Title:</b>	<input type="text" value="Acting Senior Deputy Director/State Medicaid Director"/>		
<b>Agency:</b>	<input type="text" value="District of Columbia, Department of Health Care Finance"/>		
<b>Address:</b>	<input type="text" value="441 4th Street NW, Suite 900 South"/>		
<b>Address 2:</b>	<input type="text"/>		
<b>City:</b>	<input type="text" value="Washington DC"/>		
<b>State:</b>	<b>Dist. of Columbia</b>		
<b>Zip:</b>	<input type="text" value="20001"/>		
<b>Phone:</b>	<input type="text" value="(202) 442-9075"/>	<b>Ext:</b> <input type="text"/>	<input type="checkbox"/> TTY
<b>Fax:</b>	<input type="text" value="(202) 442-4790"/>		
<b>E-mail:</b>	<input type="text" value="claudia.schlosberg@dc.gov"/>		

## Attachments

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### Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Although acupuncture services are not being continued under this waiver, no transition plan is needed because no waiver participants were receiving acupuncture services.

Community Support Team Services will be provided through the DC Medicaid State Plan Mental Health Rehabilitation Services benefit instead of through this Home and Community Based Waiver. A transition plan is not required because services will continue to be available, and this change will not affect beneficiaries.

Finally, transportation available under the Transportation –waiver service is subsumed under the Transportation-Community Access service. Since these services will continue to be available by the same vendor and in the same manner, no transition plan is needed.

The information below is specific to the Waiver Amendment:

Although Shared Living and Transportation Community Access are not being continued, no transition plan is needed because no waiver participants were receiving these services in either this waiver, or the previous waiver, although the service has been available. Additionally, given the impact of the Department of Labor (DOL) Companionship rule, D.C. would need to significantly revise the Shared Living service for compliance. Transportation is both available through the Medicaid State Plan and waiver participants are currently using that service.

### 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*

*HCBS setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

The Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) published regulations in the Federal Register on January 16, 2014, effective March 17, 2014, which, among other things, changed the definition of home and community-based services settings for Home and Community Based Services (HCBS) Waivers. The new rules also require that, at the time HCBS Waiver amendments are submitted to CMS, the Department of Health Care Finance (DHCf) and the Department on Disability Services (DDS) must also develop and submit a transition plan identifying how the HCBS Waiver will be brought into compliance with the new outcome-oriented definition of home and community-based services settings. The following is the initial proposed transition plan for the District of Columbia (D.C.) HCBS Waiver for Persons with Intellectual and Developmental Disabilities (IDD Waiver).

#### Scope

At the time of drafting, D.C. supports approximately 1580 people to live in the community through its IDD Waiver. Of those, 1005 people receive residential supports through the following services:

Supported Living: 746 people  
Residential Habilitation: 147 people  
Host Home: 85 people

The vast majority of those residential supports are provided in D.C. or within a 25 mile radius of the City.

Additionally, D.C. provides day and vocational supports through the IDD Waiver as follows:

Day Habilitation: 631 people  
Employment Readiness: 398 people  
Supported Employment: 160 People  
Individualized Day Supports: 0 People (Enrollment will begin in March 2014)

As with residential supports, the vast majority of those supports are provided in D.C., or within a 25 mile radius of the City.

#### Evaluation of Current Home and Community Based Settings & Submission of Additional Transition Plans

##### Residential Supports

D.C. will conduct a thorough evaluation, in accordance with the CMS Transition Plan Toolkit, released on March 17, 2014, to determine whether each setting in which residential supports are provided is consistent with the characteristics of a home and community-based (HCB) setting. This evaluation will be completed no later than March 20, 2015, one (1) year from the date CMS released guidance and the accompanying Toolkit on the new definition of home and community-based services settings as applied to residential supports.

D.C. will invite stakeholders to participate in a workgroup to review the HCBS waiver and implementing Medicaid regulations, the Provider Certification Review (PCR) requirements, and its Human Care Agreements (HCA), and other state requirements to ensure alignment with the new definition of HCB settings, and to recommend revisions as needed. As a result of this evaluation, D.C. will identify any needed revisions to the regulations and/ or other state requirements. D.C. will also identify any residential settings in which further evaluation is warranted, and conduct an on-site evaluation, as needed.

Once this evaluation is completed, D.C. will develop a proposal with a timeline and milestones for any required regulatory or practice revisions, and for any settings that do not meet HCB characteristics to conform with the HCBS rule. For any substantive changes proposed, D.C. will provide public notice, seek comment and revise accordingly, as required by the regulation. D.C. intends to submit this proposal and, if required, any justification or evidence that would refute the presumption that certain settings do not meet HCB characteristics to CMS by March 17, 2015, one year from the date CMS released the guidance.

##### Day and Vocational Supports

D.C. will conduct a thorough evaluation, in accordance with the forthcoming guidance from CMS, to determine whether each setting in which day and vocational supports are provided is consistent with the characteristics of a home and community-based setting. This evaluation will be completed within one (1) year from the date CMS releases guidance on the new definition of home and community-based services settings as applied to day and vocational supports. As with the assessment of residential settings, D.C. will invite stakeholders to participate in a workgroup to review the HCBS waiver and implementing Medicaid regulations, the PCR requirements, and other state requirements to ensure alignment with the new definition of HCB settings, and to recommend revisions as needed. As a result of this evaluation, D.C. will identify any needed revisions to the regulations and/or other state requirements. D.C. will also identify any day or vocational settings in which further evaluation is warranted, and conduct an on-site evaluation, as needed.

D.C. will develop a proposal based on the evaluations with a timeline and milestones for any required waiver, regulatory, policy or practice revisions, and for any settings that do not meet HCB characteristics to conform with the HCBS rule. For any substantive changes proposed, D.C. will provide public notice, seek comment and revise accordingly, as required by the regulation. D.C. intends to submit this proposal and, if required, any justification or evidence that would refute the presumption that certain settings do not meet HCB characteristics to CMS within one year from the date CMS releases the guidance for day and vocational settings.

### 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 (ID/DD). 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 ID/DD 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 ID/DD Waiver MOA. DHCF, in its Administrative Authority role, retains ultimate authority and oversight for the ID/DD Waiver and accepts complete responsibility for the entire ID/DD 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 ID/DD 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 monthly DHCF-DDS/DDA Quality Committee designed just for Waiver services. This DHCF- DDS/DDA Quality Committee is responsible for advising DHCF on the challenges that ID/DD 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 a quarterly meeting 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

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

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

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

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

Second, the DC Medicaid program contracts with a fiscal agent to administer its claims processing. A subcontractor to the District's fiscal agent has developed a template for waiver cost reporting 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

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

- ☒ **Not applicable**
- ☐ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

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

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

## Appendix A: Waiver Administration and Operation

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

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

## Appendix A: Waiver Administration and Operation

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

The contracting officers for the QIO contractor and fiscal agent assess contractor performance on regularly scheduled and ad hoc bases.

## 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	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid

## Agency

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

### a. Methods for Discovery: Administrative Authority

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

#### i. Performance Measures

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

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

*Where possible, include numerator/denominator.*

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

#### Performance Measure:

**Percent of monthly waiver expenditures by individual services in excess of estimated amounts** N/D N= actual monthly waiver expenditures by type of waiver service D= monthly budgeted waiver expenditures by type of waiver service

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

<input type="text"/>		<input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Percentage of waiver applicants seeking waiver services for whom there is indication that services will be needed in the future and who received an ICF/IDD level of care evaluation. N/D N= Number of waiver applicants who have a level of care determination  
D= Number of waiver applicants seeking services in addition to service coordination.

**Data Source (Select one):****Other**

If 'Other' is selected, specify:

**MCIS**

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

		<b>Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Random sample of five per month
	<input checked="" type="checkbox"/> <b>Other</b> Specify: The frequency for the State Medicaid Agency is on a quarterly basis.	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Percentage of participants whose initial level of care was determined by applying the appropriate process and instruments described in the approved waiver. N/D N= Number of participants whose initial eligibility evaluation includes a LON D= Number of participants in the sample.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**MCIS**

<b>Responsible Party for</b>	<b>Frequency of data</b>	<b>Sampling Approach</b> ( <i>check</i>
------------------------------	--------------------------	---



<b>data collection/generation</b> (check each that applies):	<b>collection/generation</b> (check each that applies):	<b>each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Random sample of five individuals
	<input checked="" type="checkbox"/> <b>Other</b> Specify: The frequency of data collection performed by the State Medicaid Agency is quarterly.	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Percentage of new providers required to pass initial certification within six (6) months of initial delivery of service. N/D N= number of new providers that received certification to continue to operate within six (6) months of initial delivery of services to people in the Waiver. D= Number of new providers that were approved and initiated delivery of service.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Provider Application**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Percentage of certified providers that trained staff according to DDS policies and procedures. N/D N=Number of providers that meet all applicable training indicators on the Provider Certification Review (PCR). D=Number of providers' reviewed through PCR certification.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**PCR reviews**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Percentage of DDS service coordinators trained on the waiver process for developing and managing ISPs in accordance with State requirements and the approved waiver.  
N/D N= number of Service Coordinators trained in ISP development and management in compliance with State requirements and the approved waiver D= Total number of DDS Service Coordinators responsible to develop and manage the ISP

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: The State Medicaid Agency will review a random sample of 10 staff per quarter.
	<input type="checkbox"/> Other Specify:	

	<input type="text"/>	
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**Data Aggregation and Analysis:**

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

**Performance Measure:**

Percentage of ISPs that meet standards contained in DDS training N/D N= Number of waiver participants whose ISP complies with training standards. D= Total number of ISPs reviewed.

**Data Source (Select one):****Other**

If 'Other' is selected, specify:

**DDS training record**

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 30 participant records per quarter
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Percentage of service plans that address participants' assessed needs (including health and safety risk factors) and personal goals. N/D N= Number of service plans that address the participants' assessed needs including health and safety risk factors and personal goals and needs during LON assessment process. D= Number of service plans reviewed by DDS ISP Quality Review.

**Data Source (Select one):****Other**

If 'Other' is selected, specify:

**DDS ISP Quality Reviews**

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



		Interval = <div></div>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 10% or 10 records, whichever is less
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Percentage of service plans updated/revised in response to the person's change in needs or change in supports. N/D N= Number of people who had revised ISP. D= Number of people who identified/experienced a change in needs and/or supports.

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**DDS ISP Quality Reviews**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>

<b>Agency</b>		
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Percentage of participants who received services in accordance with the service plan, including the type, scope, amount, frequency, and duration specified in the service plan. N/D N= number of people that receive services as described in the ISP in type, amount, duration, and frequency D= Total number of people who received service coordination monitoring visits.

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**DDS ISP Quality Reviews**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

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**Performance Measure:**

Percentage of participants whose service plans contain documentation that they were afforded choice between and among waiver services and providers. N/D N= number of service plans (ISPs) reviewed that include documentation D=number of ISPs reviewed

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**DDS ISP Quality Reviews**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: DDS will conduct 35 ISP Quality reviews, or 28%, whichever is less, of all ISPs approved per month, for a total of 105 per quarter or 420 annually.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: DDS will conduct 35 ISP Quality reviews, or 28%, whichever is less, of all ISPs approved per month, for a total of 105 per quarter or 420 annually.

**Performance Measure:**

**Percentage of all serious reportable incidents reported according to time frames outlined in DDS' Incident Management Procedure N/D N= number of incidents reported timely.**

**D= Number of serious reportable incidents reported.**

**Data Source (Select one):****Other**

If 'Other' is selected, specify:

**MCIS**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 20% of all incidents
	<input type="checkbox"/> <b>Other</b> Specify:	

	<input type="text"/>
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**Data Aggregation and Analysis:**

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

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

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
- Remediating and fixing individual/systemic problems are the shared responsibility of the State Agency's Continuing Care for Persons with Special Needs Branch 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.

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly



<input checked="" type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: For state Medicaid Agency, frequency of data collection is quarterly.

**c. Timelines**

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

☐ **No**

☒ **Yes**

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

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. DHCF will evaluate 100% or 15 initial LOC records and 3% of redetermination LOC, to determine if DDA completed initial and re-determination of LOC consistent with the HCBS waiver application.

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

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

## 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
<input type="checkbox"/> <b>Aged or Disabled, or Both - General</b>					
	<input type="checkbox"/>	Aged	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Disabled (Other)	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> <b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
	<input type="checkbox"/>	Brain Injury	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
		Medically Fragile			

	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	18	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Intellectual Disability	18	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	Serious Emotional Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	

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

D.C. Official Code 7-761.05(1)(a) requires DDS to provide services and supports to consumers in accordance with Chapter 13 of Title 7, which is the codification of D.C. Law 2-137, the Mentally Retarded Citizens 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 through the admission and commitment process by petition to the Family Court for residential services and by application to DDS for non-residential services. See D.C. Official Code 7-1301.03(2) and 7-1301.03 through 7-1303.06. In addition, eligibility for services is limited to individuals with an intellectual disability and other developmental disabilities under 29 DCMR § 1902.1(b), 51 DCR 10209 (Nov. 5, 2004).

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

- ☒ **Not applicable. There is no maximum age limit**
- ☐ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

## Appendix B: Participant Access and Eligibility

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

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:
- ☒ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ☐ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

- ☐ **A level higher than 100% of the institutional average.**

Specify the percentage:

☐ **Other**

*Specify:*

- ☐ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ☐ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

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

☐ **The following dollar amount:**

Specify dollar amount:

**The dollar amount (select one)**

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

Specify the formula:

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

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

Specify percent:

☐ **Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

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

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

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

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

- ☐ The participant is referred to another waiver that can accommodate the individual's needs.
- ☐ Additional services in excess of the individual cost limit may be authorized.

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

- ☐ Other safeguard(s)

Specify:

## Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1592
Year 2	1642
Year 3	1692
Year 4	1692
Year 5	1692

- 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/IIDD	
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/IIDD

**Purpose** (*describe*):

The District will reserve up to 20 slots per year for each year of the waiver to transition individuals who seek to transition from ICF/IIDD settings to HCBS waiver services.

**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/IIDD 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	35
Year 2	35
Year 3	35
Year 4 (renewal only)	35
Year 5 (renewal only)	35

## Appendix B: Participant Access and Eligibility

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

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

Transition from CFSA to DDS

**Purpose** (describe):

The District will reserve up to 15 slots per year for young adults who are wards of the District and transitioning from the Children and Family Services Administration (CFSA) to adult services in DDS/DDA.

**Describe how the amount of reserved capacity was determined:**

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

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

Waiver Year	Capacity Reserved
Year 1	35
Year 2	35
Year 3	35
Year 4 (renewal only)	35
Year 5 (renewal only)	35

## Appendix B: Participant Access and Eligibility

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

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

- ☒ The waiver is not subject to a phase-in or a phase-out schedule.
- ☐ The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the

waiver.

**e. Allocation of Waiver Capacity.**

*Select one:*

- ☒ **Waiver capacity is allocated/managed on a statewide basis.**
- ☐ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Waiver eligibility criteria are: 1) a District of Columbia resident currently receiving services from DDS/DDA; 2) a Medicaid recipient with income up to 300% of SSI; and 3) a Medicaid recipient who meets an ICF/IDD level of care criteria. Additionally, DDS/DDA will prioritize entrance into the waiver in the following manner: priority for available waiver slots are restricted to any individual who has no family or other natural support system to meet his/her assessed need for twenty-four (24) hour residential support; any identified Evans class member who chooses HCBS waiver services; and, any individual found to be a Ward of the District of Columbia who has aged out of the DC Child and Family Services Agency (CFSA) who has been in an out-of-home placement and for whom returning to a parental/natural home is not an option. Individuals in emergency situations who meet the criteria for enrollment are then considered for enrollment. Emergency is defined by DDS as an individual that has an "Emergency Need" for enrollment in the DDA HCBS waiver because the health, safety or welfare of the individual or others is in imminent danger and the situation cannot be resolved absent the provision of such services available from the waiver program. Criteria include: clear evidence of abuse, neglect, or exploitation; the death of the individual's primary caregiver and lack of alternative primary caregiver; the individual is homeless, which is defined as living in a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings; or a shelter, including a severe weather shelter, a low barrier shelter, or a temporary shelter.

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

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

**a.**

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

- ☒ **§1634 State**
- ☐ **SSI Criteria State**

☐ **209(b) State**

**2. Miller Trust State.**

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

☒ **No**

☐ **Yes**

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

---

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

---

- ☒ **Low income families with children as provided in §1931 of the Act**
- ☒ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☒ **Optional State supplement recipients**
- ☒ **Optional categorically needy aged and/or disabled individuals who have income at:**

*Select one:*

- ☒ **100% of the Federal poverty level (FPL)**
- ☐ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☒ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

*Specify:*

---

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

---

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

*Select one and complete Appendix B-5.*



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

Check each that applies:

- ☒ A special income level equal to:

Select one:

- ☒ 300% of the SSI Federal Benefit Rate (FBR)
- ☐ A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- ☐ A dollar amount which is lower than 300%.

Specify dollar amount:

- ☐ Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- ☐ Medically needy without spenddown 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 4)

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- 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 (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 4)

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

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

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

- ☒ **The following standard included under the State plan**

*Select one:*

- ☐ **SSI standard**
- ☐ **Optional State supplement standard**
- ☐ **Medically needy income standard**
- ☒ **The special income level for institutionalized persons**

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

- ☐ **Other standard included under the State Plan**

*Specify:*

- ☐ **The following dollar amount**

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

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

*Specify:*

- ☐ **Other**

*Specify:*



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

---

- ☐ **Not Applicable (see instructions)**
- ☐ **SSI standard**
- ☐ **Optional State supplement standard**
- ☐ **Medically needy income standard**
- ☐ **The following dollar amount:**

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

- ☒ **The amount is determined using the following formula:**

*Specify:*

The Minimum Monthly Maintenance Needs Allowance (MMMNA) (this amount is established annually by CMS); plus Excess shelter allowances (may include rent or mortgage payments, electric, gas, heating oil, water, and a standard telephone deduction of \$21.00); minus The community spouse's countable income (determined using SSI based methodologies)

(MMMNA + excess shelter expenses - community spouse's countable income)

---

**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

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### B-5: Post-Eligibility Treatment of Income (3 of 4)

**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.

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## Appendix B: Participant Access and Eligibility

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

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

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

---

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

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## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

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

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

**i. Minimum number of services.**

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

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

- ☐ The provision of waiver services at least monthly
- ☒ Monthly monitoring of the individual when services are furnished on a less than monthly basis

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

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

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

- ☐ Directly by the Medicaid agency
- ☒ By the operating agency specified in Appendix A
- ☐ By an entity under contract with the Medicaid agency.

*Specify the entity:*

- ☐ Other
- Specify:*

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

The Qualified Intellectual/Developmental Disability Professionals (QI/DDP), who shall oversee the initial habilitative assessments of individuals, develop ISPs, monitor and review ISPs as necessary, and integrate and coordinate services. The QIDP shall be one of the following:

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

Per Title 29 DCMR, Section 1902.4, an individual meets the level of care determination if one of the following criteria has been met:

- a) The individual's primary disability is an intellectual disability with an intelligence quotient (IQ) of 59 or less; or
- b) The individual's primary disability is an intellectual disability with an IQ of 60-69 and the individual has at least one of the following additional conditions:
  - 1. Mobility deficits;
  - 2. Sensory deficits;
  - 3. Chronic health needs;
  - 4. Behavior challenges;
  - 5. Autism;
  - 6. Cerebral Palsy;
  - 7. Epilepsy; or
  - 8. Spina Bifida.
- c) The individual primary disability is intellectual disability with an IQ of 60-69 and the individual has severe functional limitations in at least three of the following major life activities:
  - 1. Self-care;
  - 2. Understanding and use of language;
  - 3. Functional academics;
  - 4. Social Skills;
  - 5. Mobility;
  - 6. Self-direction;
  - 7. Capacity for independent living, or
  - 8. Health and Safety.
- d) The individual has an intellectual disability, has severe functional limitations in at least three of the major life activities set forth in (c) 1-8, and has one of the following diagnoses:
  - 1. Autism
  - 2. Cerebral Palsy
  - 3. Prader Willi; or
  - 4. Spina Bifida.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- ☒ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
  - ☐ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

Initial Evaluations:

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

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

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

- a) Self-Care - Score of 3 (out of 8) or higher in Personal Care;
- b) Understanding and Use of Language- Score of 2 (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 2 (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 ID/DD HCBS waiver program, the DDS/DDA service coordinator submits the waiver application package, inclusive of the medical evaluation, psychological evaluation, DC LON and Summary Report, to the DDS/DDA designated staff to complete the initial level of care determination as part of the eligibility review for the ID/DD 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:*

A level of care re-determination must be conducted on an annual basis to re-certify on-going eligibility for participation in the Medicaid program.

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

- ☒ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ☐ **The qualifications are different.**  
Specify the qualifications:

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

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 ID/DD HCBS waiver program. Timely reevaluation means a LOC reevaluation is completed on or before the effective date of the annual ISP.

The DDA service coordinator is responsible for informing individuals of all waiver services and offering a choice of service and providers to individuals during the Level of Care re-determination 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 is defined as being completed on or before the effective date of the annual ISP.

- 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:

Records are maintained in the DDS MCIS information system for a minimum of three years.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

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

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

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

- i. Sub-Assurances:**

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

#### Performance Measures

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

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



**Performance Measure:**

**LOC.i.a.i.PM.1. 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/number of people who seek services in addition to service coordination)**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Intake Database, MCIS**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: DHCF will collect information from 100% of the sample or a sample of 15 people seeking services (whichever is less) from the MCIS intake database on a quarterly basis.
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

- 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):

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

		<input type="text"/>
<input checked="" type="checkbox"/> <b>Other</b> Specify: N/A	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: N/A	

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

**Performance Measure:**

**LOC.i.c.i.PM.1.** The evaluation for the level of care including the Level of Need and Risk Assessment is completed consistent with the approved waiver. N=

Number of people whose initial eligibility includes a LON D= No. of people in the sample.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**MCIS**

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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: DHCF will review information from MCIS of 100% or 15 people seeking waiver services (whichever is less) each quarter.
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>

<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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

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

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

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

LOC.i.b.i.PM.2. All people will receive a re-evaluation for the ICF/IDD level of care annually on or before the effective date of the annual ISP. (Number of people re-evaluated on time/number of people due for a level of care re-evaluation.)

LOC.i.c.i.PM.3. The evaluation and re-evaluation for the level of care including the Level of Need and Risk Assessment are completed consistent with the approved waiver. (Number of people evaluated or re-evaluated accurately/number of people in the sample.)

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 DHC. The Service Coordination Division will report the names of people for whom an annual level of care determination was due.

DHCF conducts an audit of 100% or fifteen (15) (whichever is less) of the initial determinations to ensure approved process and instruments were applied in accordance with the waiver.

DHCF conducts an audit of 3% of the re-determinations due in the quarter to ensure that the approved process and instruments were applied in accordance with the waiver.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. 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 random sampling and corrective actions to verify whether DDS has effectively addressed any individual or systemic problems.

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

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. DHCF will evaluate 100% or 15 initial LOC records and 3% of re-determination LOC, to determine if DDA completed initial and re-determination of LOC consistent with the HCBS waiver application.

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.

## 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 all available waiver services and also provided with written material that gives information regarding all of the District's current HCBS waiver providers. The service coordinator assists the individual in choosing providers, which includes giving individuals sample questions to ask prospective providers. If needed, the service coordinator will arrange phone calls and meetings for the individual and the prospective providers. The service coordinator provides service descriptions to each individual. Service descriptions are also found on the DDS website at [www.dds.dc.gov](http://www.dds.dc.gov). An HCBS waiver fact sheet is also available for individuals and stakeholders. The form signed by the individual or designee is titled DEPARTMENT OF ECONOMIC SECURITY ADMINISTRATION, ELIGIBILITY WORKSHEET and is provided to the individual/designee by the service coordinator.

- 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 Beneficiary Freedom of Choice Documentation into the DDS MCIS database. 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.

## Appendix C: Participant Services

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

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

Service Type	Service	

Statutory Service	Day Habilitation
Statutory Service	Employment Readiness
Statutory Service	In-Home Supports
Statutory Service	Residential Habilitation
Statutory Service	Respite
Statutory Service	Supported Employment
Extended State Plan Service	Personal Care Services
Extended State Plan Service	Skilled Nursing
Other Service	Behavioral Supports
Other Service	Companion Services
Other Service	Creative Art Therapies
Other Service	Dental
Other Service	Environmental Accessibilities Adaptations
Other Service	Family Training
Other Service	Host Home
Other Service	Individualized Day Supports
Other Service	Occupational Therapy
Other Service	One-Time Transitional Services
Other Service	Personal Emergency Response System (PERS)
Other Service	Physical Therapy
Other Service	Small Group Supported Employment
Other Service	Speech, Hearing and Language Services
Other Service	Supported Living with Transportation
Other Service	Supported Living
Other Service	Vehicle Modifications
Other Service	Wellness Services

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service ▼

**Service:**

Day Habilitation ▼

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**



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

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

**Service Definition (Scope):**

Day Habilitation Services are aimed at developing activities and/or skills acquisition to support or further integrate community opportunities outside of an individual's home, to foster independence, autonomy or career exploration and encourage development of a full life in his/her community. Services are in group settings, but within these settings, individuals may receive services as part of a group or on an individualized basis. 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. A small group setting may not exceed 15 persons plus staff, as well as the number of people served. 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 individual.

The primary focus of Day Habilitation Services is acquisition of new skills or maintenance of existing skills based on individualized preferences and goals. 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.

Day Habilitation Services shall focus on enabling individuals 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.

**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, Supported Employment, or Individualized Day Supports. Provisions must be made by the provider for individuals who arrive early and depart late.

Time spent in transportation to and from the program shall not be included in the total amount of services provided per day.

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

<b>Provider Category</b>	<b>Provider Type Title</b>
Agency	Day Habilitation

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Day Habilitation**

**Provider Category:**

Agency ▼

**Provider Type:**

Day Habilitation

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

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

**Other Standard (specify):**

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;
- (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; and

- (m) Provide interpreters for non-English speaking persons and those with hearing impairments that are enrolled in the program.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially, and annually thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request

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

**Service Type:**

Statutory Service ▼

**Service:**

Prevocational Services ▼

**Alternate Service Title (if any):**

Employment Readiness

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

▼

**Category 2:**

**Sub-Category 2:**

▼

**Category 3:**

**Sub-Category 3:**

▼

**Category 4:**

**Sub-Category 4:**

▼

**Service Definition (Scope):**

A person receiving Employment Readiness Services may pursue employment opportunities at any time to enter the general work force, and services will include helping the individual to communicate effectively with supervisors, co-workers, and customers, workplace conduct and dress, following directions.

Employment Readiness Services (previously referred to as “Prevocational Services” in the approved waiver) provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the individual and his/her service and supports planning team through an ongoing person-centered planning process. Employment Readiness Services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual’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. A person receiving Employment Readiness Services may pursue employment opportunities at anytime to enter the general work force. 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 of this service, but may not comprise the entirety of the service.

Individuals receiving Employment Readiness Services must have employment-related goals in their person-centered services and supports plan and the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which an individual 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 individuals 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, co-workers 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 individuals are compensated in employment-related training services, pay must be in accordance

with the United States Fair Labor Standards Act of 1985. Individuals 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 Case Manager.

Employment Readiness Services are not available to 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).

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

Services may be furnished to an individual up to eight (8) hours per day, forty (40) hours per week, on a regularly scheduled basis, for one or more days per week unless provided as an adjunct to other day activities included in the individual's Plan of Care. This service 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, Supported Employment, or Individualized Day Supports.

Time spent in transportation to and from the program shall not be included in the total amount of services provided per day.

This service cannot be provided or billed for during the same hours on the same day as Day Habilitation; Supported Employment; In- Home Supports; and Individualized Day Supports. Also, when personal care assistance is provided by a provider of employment readiness services as a component of this service, it is included in the reimbursement rate for employment readiness service, and is not reimbursed separately from employment readiness.

**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

**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;

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 stating that employee is free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test;
- Record of completion of competency based training in communication with people with intellectual disabilities;
- Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030;
- A high school diploma or general equivalency development;
- (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.

#### Verification of Provider Qualifications

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially, and annually thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service ▼

**Service:**

Habilitation ▼

**Alternate Service Title (if any):**

In-Home Supports

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

▼

**Category 2:**

**Sub-Category 2:**

▼

**Category 3:**

**Sub-Category 3:**

▼

**Category 4:**

**Sub-Category 4:**

**Service Definition** (*Scope*):

In-Home Supports are provided to individuals in order to assist them with residing successfully in homes owned or leased by the family or individual. These services are furnished to individuals who live in a home that is leased or owned by the person(s) or their family receiving services. Services may be provided in the home or community, with the place of residence as the primary setting.

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. 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;
- 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.

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 Pre-Vocational 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.

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

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.

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

Eight (8) hour limit per 24-hour day, up to 180 days. DDS can authorize an increase in hours in the event of a temporary emergency, for which there is no other resource available or demonstrated need based on DDS-authorized utilization review process. Services may be provided for up to seven days per week.

**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

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

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

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**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.

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

- Annual documentation from a physician or other official that the employee is free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test
- Record of completion of competency based training in communication with people with intellectual disabilities
- Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910.1030.
- A high school diploma or general equivalency development
- Record of completion of competency based training in emergency procedures
- Certification in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures;
- Training needed to address the unique support needs of the individual as detailed in their Individual Support Plan; and
- Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code, §5-44-55.1 et seq.).

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially, and annually thereafter

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## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service ▼

**Service:**

Residential Habilitation ▼

**Alternate Service Title (if any):**

**HCBS Taxonomy:****Category 1:****Sub-Category 1:**

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

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

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

**Service Definition (Scope):**

Services are provided in homes of 4-6 individuals, sharing a home managed by a provider agency. Services are developed in accordance with the needs of the individual and include supports to assist individuals in acquiring, retaining and improving self-care, daily living, adaptive, and leisure skills needed to reside successfully in a shared home within the community. Supports include health care, supervision, and oversight, including 24-hour availability of response staff to meet schedules or unpredictable needs in a way that promotes maximum dignity, independence and nursing. The service provides supervision, safety, and security, but does not include the time the person is in school or employed.

**Residential Habilitation Rates include:**

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

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

Payments are not made for room and board, the cost of facility maintenance, upkeep, or improvement. The cost of transportation is included in the residential habilitation rate.

Skilled nursing in Residential Habilitation is accounted for in the rate for routine physical assessment, as needed, the development of Health Care Management plans, nursing assessments, as needed, oversight of non-licensed



Medication Administration personnel or LPN's, and/or actual administration of medications. There is no service overlap as Skilled Nursing is not authorized in Residential Habilitation settings as a separate Extended State Plan Service.

Skilled Nursing as an Extended State Plan service is only authorized for individuals who live in Host Homes, Supported Living, independently, or in their natural homes. Edits for Residential Habilitation are in the MMIS system to ensure there is no duplication or overlap of skilled nursing services.

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

This service may not be used in combination with any other waiver residential support service on the same day. This includes Supported Living, Host Home, In-home Respite, In-home Support, or Personal Care. Service may not be billed for more than 365 days a year.

**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	Residential Habilitation Agencies

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Residential Habilitation**

**Provider Category:**

Agency ▼

**Provider Type:**

Residential Habilitation Agencies

**Provider Qualifications**

**License** (*specify*):

Homes: Chapter 35 of Title 22 of the District of Columbia Municipal Regulations- "Licensure of Group Homes for Mentally Retarded Persons"

**Certificate** (*specify*):

DDS Provider Certification Review per DDS Policy

**Other Standard** (*specify*):

Each provider of residential habilitation services shall:

Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for residential habilitation services under the Waiver;

- Providers may have a current Human Care Agreement with DDS for the provision of residential services; and
- Ensure that the service provided is consistent with the client's IHP or ISP;

All employees must have:

- A Record of completion of competency based training in communication with people with intellectual disabilities;
- Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor

regulations at 29 CFR 1910. 1030;

- A high school diploma or general equivalency development;
- Record of completion of competency based training in emergency procedures;
- Certification in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures; and
- Training needed to address the unique support needs of the individual as detailed in their
- Documentation that each employee is eighteen (18) years of age or older
- Annual

#### 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:**

**Category 2:**

**Sub-Category 2:**

**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 individual, including vacations. It may also be used in case of emergencies. Respite is only provided to those individuals who live in their own home, or their family home. Respite care will ensure that individuals have access to community activities as delineated in the individual'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. Respite care is in the individual's place of residence.

This service is necessary to prevent individuals from being institutionalized or sent to an out-of-District program.

Respite care will ensure that individuals have access to community activities as delineated in the individual'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 individual would receive if they were not in respite. These community activities would allow the individual's routine to not be interrupted.

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

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

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

**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 agreement.

For individual employees, the following requirements apply:

- Documentation that each employee is eighteen (18) years of age or older;

- Documentation that each employee was found acceptable by the individual;
- Annual documentation from a physician or other official that the employee is free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test;
- Record of completion of competency based training in communication with people with intellectual disabilities;
- Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030;
- A high school diploma or general equivalency development;
- Record of completion of competency based training in emergency procedures;
- Certification in cardiopulmonary resuscitation (CPR) and First Aid;
- 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, § 54-55.1 et seq.).

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially and annually thereafter

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

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

**Service Type:**

Statutory Service ▼

**Service:**

Supported Employment ▼

**Alternate Service Title (if any):**

**HCBS Taxonomy:****Category 1:****Sub-Category 1:**

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

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

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

	▼
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**Service Definition (Scope):**

Supported Employment Individual Services are designed to provide opportunities for individuals 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. Any individual earning below minimum wage must receive career planning designed to transition that individual to at least minimum wage over a specified time period. Supported Employment services are also provided to individuals with ongoing support needs for whom competitive employment has not traditionally occurred. In addition to the need for an appropriate job match that meets the individual's skills and interests, individuals with the most significant disabilities may also need long term employment support to successfully maintain a job due to the ongoing nature of the individual's support needs, changes in life situations, or evolving and changing job responsibilities. Stabilization services are a component of Supported Employment Services and are ongoing services needed to support and maintain an individual in an integrated competitive employment site or customized home-based employment.

Supported Employment Individual Services is not intended for people working in mobile work crews of small groups of people with disabilities in the community. The type of work support is addressed in Supported Employment Small Group service definition.

Supported Employment is:

1. Vocational assessments: All vocational assessments, regardless of the individual's vocational placement, are conducted by supported employment providers;
2. 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;
3. 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.

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.

**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;
2. 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
  3. 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 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).

#### 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, Employment Readiness, or Individualized Day 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: Statutory Service**  
**Service Name: Supported Employment**

#### Provider Category:

Agency ▼

#### Provider Type:

Supported Employment Provider

#### Provider Qualifications

##### License *(specify):*

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

##### Certificate *(specify):*

DDS Provider Certification Review per DDS Policy

##### 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.

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;
- 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.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially, and annually thereafter

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

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

**Service Type:**

Extended State Plan Service ▼

**Service Title:**

Personal Care Services

**HCBS Taxonomy:****Category 1:****Sub-Category 1:****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 individuals with routine activities of daily living including bathing, toileting, transferring, dressing, eating, feeding self, and assisting with bowel and bladder control movements. These services shall be provided when the eight hour per day limit on personal care services furnished under the State Plan limits is insufficient (i.e., services are needed in excess of eight hours per day). The scope and nature of these services do not differ from personal care services furnished under the State plan. The provider qualifications specified in the State Plan apply.

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

May be delivered on the same day as In-Home Supports. May not be delivered on the same day as Host Home, Residential Habilitation or Supported Living services.

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Care Agency

## 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.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS; Department of Health: Health Regulation Administration

**Frequency of Verification:**

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



## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Extended State Plan Service ▼

**Service Title:**

Skilled Nursing

**HCBS Taxonomy:**

**Category 1:**

▼

**Sub-Category 1:**

**Category 2:**

▼

**Sub-Category 2:**

**Category 3:**

▼

**Sub-Category 3:**

**Category 4:**

▼

**Sub-Category 4:**

**Service Definition (Scope):**

Skilled Nursing Services are services listed in the Plan of Care that are within the scope of the District's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse licensed to practice in the District of Columbia. Waiver individuals must exhaust all available skilled nursing visits provided under the District's Medicaid State Plan Services prior to receiving Skilled Nursing services through this Waiver.

Skilled Nursing services must be included in the Individual's Plan of Care, 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. The Nurse should submit updates to the State every 60 days if there are any changes to the individual's needs and/or Physician's orders.

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

Skilled Nursing as an Extended State Plan service is only authorized for individuals who live in Host Homes, Supported Living, independently, or in their natural homes. Skilled nursing in Residential Habilitation and Supported Living with Skilled Nursing is accounted for in the rates for these services. Skilled nursing as a separate waiver service is not authorized in residential habilitation, supported living with skilled nursing settings as a separate Extended State Plan Service. Edits for residential habilitation, and supported living with skilled nursing are in the MMIS system to ensure there is no duplication or overlap of skilled nursing services.

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

Skilled Nursing as a separately billed waiver service is not available in residential habilitation, or supported living with skilled nursing.

The number of nursing visits per calendar year is limited to 52 after all nursing visits allowed by State Plan have been exhausted. One to one extended nursing daily limits can be increased to twenty four (24) hours a day only for an individual on a ventilator or requiring frequent tracheal suctioning, after State Plan daily limits are

maximized. Also for an individual on a ventilator or requiring frequent tracheal suctioning, annual limits can be extended with prior approval for up to 365 days after State Plan annual limits are exhausted.

**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:**

Behavioral Supports

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

▼

**Category 2:**

**Sub-Category 2:**

▼

**Category 3:**

**Sub-Category 3:**

▼

**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.

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 persons 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.

#### **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 DDA Behavioral Health Officer with approval by the Restricted Control Review Team as necessary.

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.

For tier 2 behavioral supports, the following hours shall be permitted:

Development of a new BSP = 5 hours;

Review and updating of existing BSP = 3 hours;

Training for the person, person's family, residential and day staff, and support team = 8 hours;

On-site consultation and observation = 10 hours;

Participation in behavioral review meetings or support team meetings = 10 hours;

Quarterly reports and monthly data monitoring = 10 hours;

Participation in psychotropic medication review meetings = 4 hours; and

Counseling hours= 26 hours.

For tier 3 behavioral supports, the following hours shall be permitted:

Development of a new BSP = 12 hours;

Review and updating of existing BSP = 8 hours;

Training for the person, person's family, residential and day staff, and support team = 20 hours;

On-site consultation and observation = 24 hours;  
 Participation in behavioral review meetings or support team meetings = 20 hours;  
 Quarterly reports and monthly data monitoring = 12 hours  
 Participation in psychotropic medication review meetings = 4 hours;  
 and  
 Counseling hours = 52 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
Individual	Licensed Graduate Social Worker
Individual	Advance Practice Registered Nurse
Individual	Behavior Specialist
Individual	Psychiatrist
Individual	Licensed Clinical Social Worker
Agency	Mental Health Core Service Agency
Agency	Home Care Agency
Individual	Licensed Professional Counselor
Individual	Psychologist

## 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, LCSW, LGSW and licensed professional counselor or closely related field, and at least one year of experience serving people with developmental disabilities. Knowledge and experience in behavioral analysis is preferred. In order to receive Medicaid reimbursement, a LGSW may provide counseling under the supervision of an LICSW or a LISW in accordance with the requirements set forth in Section 3413 of Chapter 34 of Title 22 of the DCMR.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially and annually thereafter

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Behavioral Supports****Provider Category:**

Individual ▾

**Provider Type:**

Advance Practice Registered Nurse

**Provider Qualifications****License (specify):**

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

**Certificate (specify):**

**Other Standard (specify):**

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

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, LCSW, 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:**

Psychiatrist

**Provider Qualifications**

**License** (*specify*):

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

**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially and annually thereafter

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Behavioral Supports

**Provider Category:**

Individual ▾

**Provider Type:**

Licensed Clinical Social Worker

**Provider Qualifications**

**License** (*specify*):

DCMR Title 17, Chapter 70/Social Worker

**Certificate** (*specify*):

DCMR Title 17, Chapter 70/Social Worker

**Other Standard** (*specify*):

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

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially and annually thereafter

## Appendix C: Participant Services

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### 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

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

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**Service Type:** Other Service

**Service Name:** Behavioral Supports

---

**Provider Category:**

Agency ▼

**Provider Type:**

Home Care Agency

**Provider Qualifications****License** (*specify*):

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



**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially and annually thereafter

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Behavioral Supports

**Provider Category:**

Individual ▼

**Provider Type:**

Licensed 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:**

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, 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: 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:**

**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.

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

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

Companion services may be paired with In-Home Supports, Periodic Supported Living, and/or Personal Care Services at any time during the 24 hour day. It cannot be provided at the same time as In-Home Supports, Periodic Supported Living, Personal Care Services, Respite, Host Home, and/or Behavioral Supports Non-Professional.

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

N/A

**Certificate** (*specify*):

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

**Other Standard** (*specify*):

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

For individual employees, the following requirements apply:

- Documentation that each employee is eighteen (18) years of age or older;
- Documentation that each employee was found acceptable by the individual;
- Annual documentation from a physician or other official that the employee is free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin

Test;

- Record of completion of competency based training in communication with people with intellectual disabilities;
- Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030;
- A high school diploma or general equivalency development;
- Record of completion of competency based training in emergency procedures;
- Certification in cardiopulmonary resuscitation (CPR) and First Aid;
- Training needed to address the unique support needs of the individual as detailed in their Plan of Care; and
- Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law

12- 238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13,2002 (D.C. Law 14-98; D.C. Official Code, §5 44-55 1 et seq.).

#### Verification of Provider Qualifications

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially and Annually Thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▼

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

**Service Title:**

Creative Art Therapies

**HCBS Taxonomy:**

**Category 1:**

▼

**Sub-Category 1:**

**Category 2:**

▼

**Sub-Category 2:**

**Category 3:**

▼

**Sub-Category 3:**

**Category 4:**

▼

**Sub-Category 4:**

**Service Definition (Scope):**

The goal of Creative Art Therapies services (part of “Professional Services” in the currently approved waiver) is

to provide therapeutic supports to help a person with disabilities to express and understand emotions through artistic expression and through the creative process. Through these therapeutic services and processes, people can increase awareness of self and others, cope with symptoms of stress and traumatic experiences, enhance cognitive abilities, and enjoy the life-affirming pleasures of engaging in these types of therapies. Creative art 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 Art Therapies. The goal of Creative Art 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 art therapy services include: Art Therapy, Dance Therapy, Drama Therapy and Music Therapy.

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

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

There is \$2,250 per individual, per calendar year cap for Creative Art 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	Drama Therapist
Individual	Dance Therapist
Individual	Art Therapist
Individual	Music Therapist

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Creative Art Therapies

**Provider Category:**

Individual ▼

**Provider Type:**

Drama Therapist

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Drama Therapists certified by the National Association for Drama Therapy

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially and annually thereafter

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Creative Art Therapies

**Provider Category:**

Individual ▾

**Provider Type:**

Dance Therapist

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially, and annually thereafter

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Creative Art Therapies

**Provider Category:**

Individual ▾

**Provider Type:**

Art Therapist

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially and annually thereafter

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Creative Art Therapies

**Provider Category:**

Individual ▼

**Provider Type:**

Music Therapist

**Provider Qualifications**

**License** (*specify*):

N/A

**Certificate** (*specify*):

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

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially and annually thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▼

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

**Service Title:**

Dental

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

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

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

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

**Service Definition (Scope):**

Dental services under this waiver are identical to dental services offered under the District of Columbia's Medicaid state plan. The inclusion of dental services in the waiver is for the sole purpose of providing an enhanced reimbursement rate to dentists who serve people with ID/DD. DC Medicaid can only identify these individuals in two ways: 1) by their enrollment in this waiver; and 2) by their receipt of services in an ICF/MR. Enhanced payments are provided for both of these groups of individuals - waiver and non waiver.

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

If the individual 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.

**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	Dentist

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Dental****Provider Category:**

Individual

**Provider Type:**

Dentist

**Provider Qualifications****License (specify):**

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

**Certificate (specify):**

**Other Standard (specify):**



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

#### Verification of Provider Qualifications

##### Entity Responsible for Verification:

DDS

##### Frequency of Verification:

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

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

#### Service Type:

Other Service ▼

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

#### Service Title:

Environmental Accessibilities Adaptations

#### HCBS Taxonomy:

##### Category 1:

##### Sub-Category 1:

▼

##### Category 2:

##### Sub-Category 2:

▼

##### Category 3:

##### Sub-Category 3:

▼

##### Category 4:

##### Sub-Category 4:

▼

#### Service Definition (*Scope*):

Physical adaptations to the home, required by the individual's Plan of Care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home. Home modification funds are not intended to cover basic construction costs. Waiver funds can be used to cover the difference between constructing a bathroom and building an accessible or modified bathroom, but in any situation, funds must pay for a specific approved adaptation.

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual. Modifications may be applied to rental or leased property with the written approval of the landlord and approval of DDS. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, exterior fencing, general home repair and maintenance, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable District building codes.

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

For each individual receiving this service, there is a cap of \$10,000 over a five year period. On a case by case basis, with supporting documentation and based on need, a individual may be able to exceed this cap with the approval of DDS and prior authorization for the amount that exceeds the cap. No more than two residences can be modified in a five year period; however, exceptions may be approved by DDS.

**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	Building Contractors

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Environmental Accessibilities Adaptations

**Provider Category:**

Individual ▾

**Provider Type:**

Building Contractors

**Provider Qualifications**

**License** (*specify*):

Contractor's Basic Business License issued by the District of Columbia Department of Consumer and Regulatory Affairs

**Certificate** (*specify*):

**Other Standard** (*specify*):

Have a Medicaid Provider Agreement

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially for enrollment of providers and at time of service delivery to verify qualification remain in place.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▾

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

**Service Title:**

Family Training

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to individuals. 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 an individual served by the waiver. Training includes instruction about treatment regimens and other services included in the plan of care, use of equipment specified in the plan of care, and includes updates as necessary to safely maintain the individual at home. Counseling may be aimed at assisting the unpaid caregiver in meeting the needs of the individual. All training and counseling must be included in the individual's plan.

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

Services are limited to 4 hours per day and 100 hours per year. Requests for additional hours may be approved if the request passes a clinical review by staff designated by the Deputy Director for the Department on Disability Services/Developmental Disability Administration to provide oversight on clinical services.

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Licensed Graduate Social Worker
Individual	Educator
Individual	Physical Therapist
Individual	Occupational Therapist
Agency	Family Training Provider
Individual	Speech/Language Therapist
Agency	Home Care Agency

Individual	Licensed Clinical Social Worker
Individual	Registered Nurse

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Family Training**

**Provider Category:**

Individual ▼

**Provider Type:**

Licensed Graduate Social Worker

**Provider Qualifications**

**License (specify):**

DCMR Title 17, Chapter 70/Social Worker

**Certificate (specify):**

**Other Standard (specify):**

Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code, § 54-55.1 et seq.).

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially on enrollment and annually thereafter

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Family Training**

**Provider Category:**

Individual ▼

**Provider Type:**

Educator

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Teacher's Certification in DC, MD or VA.

Teachers must hold a Master's Degree in Special Education from an accredited college or university.

**Other Standard (specify):**

Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code, § 54-55.1 et seq.).

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially on enrollment and annually thereafter

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Family Training****Provider Category:**

Individual ▾

**Provider Type:**

Physical Therapist

**Provider Qualifications****License (specify):**

Title 22 DCMR, Chapter 30

**Certificate (specify):****Other Standard (specify):**

Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code, § 54-45.1 et seq.).

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially on enrollment and annually thereafter

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Family Training****Provider Category:**

Individual ▾

**Provider Type:**

Occupational Therapist

**Provider Qualifications****License (specify):**

Title 17, DCMR, Chapter 63, Occupational Therapy

**Certificate (specify):****Other Standard (specify):**

Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code, § 54-45.1 et seq.). Verification of Provider Qualifications

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially on enrollment and annually thereafter

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Family Training****Provider Category:**

Agency ▼

**Provider Type:**

Family Training Provider

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

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

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially on enrollment and annually thereafter

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Family Training****Provider Category:**

Individual ▼

**Provider Type:**

Speech/Language Therapist

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

Accreditation by the American Speech-Language-Hearing Association.

Record of criminal background check consistent with the requirements of the Health-Care Facility  
Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law

12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code, § 54-55.1 et seq.).

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially on enrollment and annually thereafter

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Family Training****Provider Category:**

Agency ▼

**Provider Type:**

Home Care Agency

**Provider Qualifications****License (specify):**

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

**Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS, DOH, HRLA

**Frequency of Verification:**

Initially on enrollment and annually thereafter

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Family Training****Provider Category:**

Individual ▼

**Provider Type:**

Licensed Clinical Social Worker

**Provider Qualifications****License (specify):**

DCMR Title 17, Chapter 70/Social Worker

**Certificate (specify):**

**Other Standard (specify):**

Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code, § 54-45.1 et seq.).

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially on enrollment and annually thereafter

## Appendix C: Participant Services

---

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

---

**Service Type:** Other Service

**Service Name:** Family Training

---

**Provider Category:**

Individual ▾

**Provider Type:**

Registered Nurse

**Provider Qualifications****License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Nurses are licensed under §302(14) of the District of Columbia Health Occupations Revision Act of 1985, D.C. Law 6-99, D.C. Code §2-3303.2(14) (1988 Repl. Vol.), 33 DCR 729, 732 (February 7, 1986), and Mayor's Order 86-110, 33 DCR 5220 (August 22, 1986)/ Title 17, Chapter 54 (Registered Nursing).

Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code, § 54-45.1 et seq.).

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially on enrollment and annually thereafter

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

---

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

**Service Type:**

Other Service ▾



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

**Service Title:**

Host Home

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition** (*Scope*):

Host Home services enable individuals to retain or improve skills related to health, activities of daily living, money management, community mobility, recreation, cooking, shopping, use of community resources, community safety and other adaptive skills needed to live in the community. Host Home services are provided in a private home by a principal care provider who lives in the home and either rents or owns the home. Host Home services are furnished to waiver individuals who require up to 24-hour services as determined by a District-managed assessment process and Plan of Care. Residential and community integration services are delivered in conjunction with residing in the home.

The total number of individuals (including those served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed three. Host Home services are provided by a person(s) unrelated to the individual or a family member, but not a parent, spouse or legally responsible relative. The Host Home is responsible for participating in and abiding by the Plan of Care as well as maintaining records in accordance with State and provider requirements.

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

Waiver payments are not made for room and board.

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

For individuals receiving Host Home services, separate payment will not be made for Respite since these services are integral to and inherent in the provision of Host Home services. This service may not be used in combination with Residential Habilitation, Supported Living, or In-Home Supports. This service may not be used if it is billed for the same day of service that the following ID/DD Waiver services are provided: Residential Habilitation, Supported Living, In-Home Supports, Personal Care Services, Skilled Nursing, and EAA. However, a person in host home may receive Personal Care Services if they are employed.

**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 Living Provider
Agency	Residential Habilitation Provider

## Appendix C: Participant Services

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

Service Type: Other Service  
Service Name: Host Home

Provider Category:

Agency ▼

Provider Type:

Supported Living Provider

Provider Qualifications

License (specify):

Certificate (specify):

DDS Provider Certification Review per DDS Policy

Other Standard (specify):

Provider should be enrolled to provide services through DDS/DHCF and have a current Medicaid agreement. Also, they may be required to maintain a human care agreement with DDS for the provision of residential services.

For individual employees, the following requirements apply:

- Documentation that each employee is eighteen (18) years of age or older;
- Documentation that each employee was found acceptable by the individual;
- Annual documentation from a physician or other official that the employee is free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test;
- Record of completion of competency based training in communication with people with intellectual disabilities;
- Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030;
- A high school diploma or general equivalency development;
- Record of completion of competency based training in emergency procedures;
- Certification (active) in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures;
- Training 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, §54-55 1 et seq.).

#### Verification of Provider Qualifications

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially, and annually thereafter

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Host Home**

#### Provider Category:

Agency ▼

#### Provider Type:

Residential Habilitation Provider

#### Provider Qualifications

**License (specify):**

**Certificate (specify):**

DDS Provider Certification Review per DDS Policy

**Other Standard (specify):**

Providers enrolled should provide services through DDS/DHCF, and have a current Medicaid agreement. In addition, they may be required to have a current Human Care Agreement with DDS for the provision of residential services.

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 employee is free from all communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test;
- Record of completion of competency based training in communication with people with intellectual disabilities;
- Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030;
- A high school diploma or general equivalency development;
- Record of completion of competency based training in emergency procedures;
- Certification (active) in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures;
- Training 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, §54-55 1 et seq.).

#### Verification of Provider Qualifications

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially, and annually thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▼

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

**Service Title:**

Individualized Day Supports

**HCBS Taxonomy:**

**Category 1:**

▼

**Sub-Category 1:**

**Category 2:**

▼

**Sub-Category 2:**

**Category 3:**

▼

**Sub-Category 3:**

**Category 4:**

▼

**Sub-Category 4:**

**Service Definition (Scope):**

Note to CMS: Waiver portal will not allow us to select multiple Day Habilitation Statutory Services. In order to validate and submit this waiver, we changed the Service Type to "Other Service" instead of Day Habilitation "Statutory Service".

Individualized Day Supports services provide habilitative services to individuals in order to attain new and maintain existing skills based on individualized preferences and goals. The activities that the individual 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 an individual for community participation and/or meaningful retirement activities, 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. 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 individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the Person Centered Plan. Individualized Day Supports services are to meet the day programming needs of individuals who choose not to attend or receive services provided in a larger formal group

setting, such as Day Habilitation. Community activities that originate from a facility based day setting can be provided and billed as Individualized Day Supports. On site attendance at the licensed setting is not required to receive services that originate from the setting.

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

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.

**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 eight (8) 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.

Time spent in transportation to and from the program shall not be included in the total amount of services provided per day.

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

The Individualized Day Program cannot be provided by the same staff person who provides Supported Living, Residential Habilitation, Host Home or In-Home Supports services. Individualized Day Supports cannot be provided concurrently as Day Habilitation because these services 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.

**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	Individualized Day Support

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Individualized Day Supports**

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**Provider Category:**

Agency ▼

**Provider Type:**

Individualized 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.

For individual employees, the following requirements apply:

- Documentation that each employee is eighteen (18) years of age or older;
- Annual documentation from a physician or other official that the employee is free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test;
- Record of completion of competency based training in communication with people with intellectual disabilities;
- Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030.;
- A high school diploma or general equivalency development;
- Record of completion of competency based training in emergency procedures;
- Certification in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures;
- Training needed to address the unique support needs of the individual as detailed in their Individual Support Plan;
- Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code, §5 44-55 1 et seq.);
- and
- They must have at least one year experience working with individuals with Intellectual Developmental Disabilities (IDD).
- 

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially, and annually thereafter

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**Appendix C: Participant Services**

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**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:**

▼

**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.

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

If the individual 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 staff designated by the Deputy Director for the Department on Disability Services/Developmental Disability Administration to provide oversight on clinical services.

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

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

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

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

**Provider Specifications:**

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Provider Category	Provider Type Title
Individual	Occupational Therapist
Agency	Home Care Agency

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Occupational Therapy

**Provider Category:**

Individual ▼

**Provider Type:**

Occupational Therapist

**Provider Qualifications**

**License** (*specify*):

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

**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially and annually thereafter

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Occupational Therapy

**Provider Category:**

Agency ▼

**Provider Type:**

Home Care Agency

**Provider Qualifications**

**License** (*specify*):

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

**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS, Department of Health, HRLA

**Frequency of Verification:**



Initially and annually thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▼

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

**Service Title:**

One-Time Transitional Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

▼

**Category 2:**

**Sub-Category 2:**

▼

**Category 3:**

**Sub-Category 3:**

▼

**Category 4:**

**Sub-Category 4:**

▼

**Service Definition (Scope):**

One-Time Transitional Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the individual is directly responsible for their own living expenses. Allowable expenses are those necessary to enable an individual to establish a basic household that does not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure needed resources.

One-Time Transitional Services are furnished only to the extent that they are reasonable and necessary as determined through the Plan of Care development process, clearly identified in the Plan of Care, and the individual is unable to meet such expenses or the services cannot be obtained from other sources. One-Time Transitional Services do not include monthly rental or mortgage expenses; food; regular utility charges; and/or household appliances or items that are intended purely for recreational purposes; environmental accessibility adaptations services that are of direct medical or remedial benefit to the person, or any durable medical equipment. One-Time Transitional Services are a one-time, one-unit service. The unit should be noted as a service.

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

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

records.

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

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

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

- ☐ Legally Responsible Person  
☐ Relative  
☐ Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Supported Living Provider
Agency	Residential Habilitation Provider

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** One-Time Transitional Services

**Provider Category:**

Agency ▼

**Provider Type:**

Supported Living Provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially and annually thereafter

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** One-Time Transitional Services

**Provider Category:**

Agency ▼

**Provider Type:**

Residential Habilitation Provider

**Provider Qualifications****License** (*specify*):

DCMR Chapter 35 licensure

**Certificate** (*specify*):
**Other Standard** (*specify*):

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

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially and annually thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**


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:****Category 2:**

**Sub-Category 2:****Category 3:**

**Sub-Category 3:****Category 4:**

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

Personal Emergency Response System (PERS) is 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.

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

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.

**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	Medical Personnel
Individual	Self-Employed Individual
Agency	Business Entity (Emergency Response Center)

## 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:**

Medical Personnel

**Provider Qualifications**

**License** (*specify*):

Medical personnel acting as emergency responders shall be licensed to practice medicine, registered nursing, practical nursing, or physician assistance pursuant to section 501 of the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1205.01), or be licensed to practice their respective profession within the jurisdiction where they provide service.

**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially and annually thereafter

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name: Personal Emergency Response System (PERS)****Provider Category:**

Individual ▾

**Provider Type:**

Self-Employed Individual

**Provider Qualifications****License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

For individual employees acting as emergency responders, the following requirements apply:

- Documentation that each employee is eighteen (18) years of age or older;
- Annual documentation from a physician or other official that the employee is free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test;
- Record of completion of competency based training in communication with people with intellectual disabilities;
- Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030.;
- A high school diploma or general equivalency development;
- Record of completion of competency based training in emergency procedures;
- Certification in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures;
- Training needed to address the unique support needs of the individual as detailed in their Individual Support Plan;
- 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, § 54-551 et seq.);
- and
- They must have at least one year experience working with individuals with Intellectual Developmental Disabilities (I/DD).

•In addition, each person providing PERS services who will be in direct contact with the person shall also have the language and communication skills to respond to emergency contacts (i.e., calling emergency 911 on behalf of the person).

**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:**

Business Entity (Emergency Response Center)

**Provider Qualifications****License** (*specify*):

Medical personnel involved in this service as an emergency responders must conform to the standards delineated in the District of Columbia Title 2, Chapter 33, Sections 1.2201 – 2.3312 of the DC Health Occupations Revision Act (Department of Consumer and Regulatory Affairs, Occupational and Professional Licensing Administration).

**Certificate** (*specify*):

PERS providers shall have a current license, certification, or registration with the District of Columbia as appropriate for the type of electronic system being purchased. The provider shall also possess a current license to do business issued in accordance with the laws of the District of Columbia. The provider shall demonstrate knowledge of applicable standards of manufacture, design and installation.

**Other Standard** (*specify*):
**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially and annually thereafter

## Appendix C: Participant Services

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### 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:**

**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, and maintain health.

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

This is not an extended state plan service. This service may be used in addition to or in place of the state plan service if indicated as needed by the physician. This service differs from the state plan service by provider qualifications and locations where the service may be delivered. The 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 is delivered in the individual's home or day service setting.

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

If the individual 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 quality control when authorizing service plans to monitor the appropriate use of EPSDT and other State Plan services as appropriate. Services are limited to 4 hours per day and 100 hours per calendar year. Requests for additional hours may be approved when accompanied by a physician's order or if the request passes a clinical review by staff designated by the Deputy Director for the Department on Disability Services/Developmental Disability Administration to provide oversight on clinical services.

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

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

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ 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:**

Small Group Supported Employment



**HCBS Taxonomy:****Category 1:****Sub-Category 1:**

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

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

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

**Service Definition (Scope):**

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

Supported Employment - Small Group are services and training activities provided in regular business, industry and community settings for groups of two (2) to eight (8) workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in the community. Small Group Supported Employment must be provided in a manner that promotes integration into the workplace and interaction between individuals and people without disabilities in those workplaces.

Personal care/assistance to the individual may be a component part of supported employment, small group employment support services, but may not comprise the entirety of the service. Individuals should be provided information to make an informed decision in choosing between supported employment, small group employment supports and supported employment individual employment support services.

**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 pre-vocational 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 transportation to and from the program for the purpose of training the individual 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 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 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).

**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.

**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:** Small Group Supported Employment

**Provider Category:**

Agency ▼

**Provider Type:**

Supported Employment Provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

DDS Provider Certification Review per DDS Policy

**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.

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;
- 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.

#### Verification of Provider Qualifications

##### Entity Responsible for Verification:

DDS

##### Frequency of Verification:

Initially, and annually thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

#### Service Type:

Other Service ▼

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

#### Service Title:

Speech, Hearing and Language Services

#### HCBS Taxonomy:

##### Category 1:

##### Sub-Category 1:

▼

##### 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 individual's Plan of Care. All Speech, Hearing and Language Therapy services will be monitored to determine which services are most appropriate to enhance the individual'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 and the service is delivered in the home or vocational service setting as prescribed by the ISP.

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

If the individual 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. Services are limited to 4 hours per day and 100 hours per year. Requests for additional hours may be approved when accompanied by a physician's order or if the request passes a clinical review by staff designated the Deputy Director for the Department on Disability Services/Developmental Disabilities Administration to provide oversight on clinical services.

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

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

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

- ☐ Legally Responsible Person  
☐ Relative  
☐ Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Audiologists
Individual	Speech Pathologists

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Speech, Hearing and Language Services

**Provider Category:**

Individual ▼

**Provider Type:**

Audiologists

**Provider Qualifications**

**License** (*specify*):

An audiologist licensed to practice audiology in accordance with the requirements of Chapter 78 of Title 17 of the D.C.M.R.

**Certificate** (*specify*):

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

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially, and annually thereafter

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Speech, Hearing and Language Services

**Provider Category:**

Individual ▼

**Provider Type:**

Speech Pathologists

**Provider Qualifications**

**License** (*specify*):

A Speech Pathologist licensed to practice speech pathology in accordance with the requirements of

Chapter 79 of Title 17 of the D.C.M.R.

**Certificate** (*specify*):

**Other Standard** (*specify*):

Accreditation by the American Speech-Language-Hearing Association

**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:**

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

**Service Title:**

Supported Living with Transportation

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition** (*Scope*):

Note to CMS: Waiver portal will not allow us to select multiple Habilitation Statutory Services. In order to validate and submit this waiver, we changed the Service Type to "Other Service" instead of Habilitation "Statutory Service".

This service is defined as that which provides support to individuals who have limited informal supports and have an assessed need for assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed-making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Supported Living with Transportation is provided in a home that is owned or leased and operated by the agency, or owned or leased by the individual or his/her family. Transportation is included in this

service to provide routine and urgent medical care transportation and facilitate community access for individuals. Individuals will continue to use State Plan emergency medical transportation services to access medically necessary emergency services.

The Supported Living with Transportation Service has three categories of each Supported Living Service, Basic, Moderate and Intensive with two sub-categories of each. Additionally, each category provides services in a home with either one (individualized supports), two (2), or three (3) residents.

The categories are as follows:

- Basic Supported Living 1: Basic Support Level 1 provides asleep overnight support for 3 persons and covers a direct care support ratio of 1:3 during all hours when individuals are awake and receiving services.
- Basic Supported Living 2: Basic Support Level 2 provides awake overnight daily rate support for 3 persons and covers a direct care support ratio of 1:3 for awake overnight and 1:3 during all awake hours when individuals are receiving services.
- Moderate Supported Living 1: Moderate Support Level 1 provides asleep overnight for 3 persons for a staff support ratio of 2:3 for 8 hours a day, 1:3 during remaining awake hours, and 1:3 asleep coverage when individuals are receiving services.
- Moderate Supported Living 2: Moderate Support Level 2 provides awake overnight with 3 residents for a staff support ratio of 2:3 for 8 hours a day, 1:3 during remaining awake hours, and 1:3 awake coverage when individuals are receiving services.
- Intensive Supported Living 1: Intensive Support Level 1 with 3 residents covers a direct care support ratio of 1:3 for awake overnight and 2:3 during all awake hours when individuals are receiving services and adjusted for increased absenteeism from day and employment services.
- Intensive Supported Living 2: Intensive Support Level 2 with 3 residents covers a direct care support ratio of 2:3 for awake overnight and 2:3 during all awake hours when individuals are receiving services and adjusted for increased absenteeism from day and employment services.

**Intensive Individualized Supported Living:** Provides intensive individualized staffing to support a person due to complex behaviors that may involve a serious risk to the health, safety or well-being of the person or others, or when required by court order.

**Supported Living with Nursing:** Provides twenty-four (24) hour supported living services with skilled nursing for people who have a circulatory, respiratory, gastro-intestinal, or neurological condition or any other serious medical condition that requires frequent monitoring or at least hourly care.

**Supported Living Periodic:** Provides intermittent supported living services to people who demonstrate a need for the acquisition, and improvement of skills related to activities of daily living and the social and adaptive skills necessary for community residence, as indicated in the ISP; and are willing to be supported in their own home or SLR's without twenty four (24) hour supports and supervision.

**Basic Support Level 1:** Provides asleep overnight support for a home with two (2) residents and a direct care staff support ratio of 1:2 staff asleep overnight coverage and 1:2 staff awake coverage when residents are receiving services;

**Basic Support Level 2:** Provides overnight support for a home with two (2) residents and a direct care staff support ratio of 1:2 for staff awake overnight and 1:2 during all awake hours when the resident is receiving services;

**Moderate Support Level 1:** Provides awake overnight daily rate for a home with two (2) residents and a direct care staff support ratio of 2:2 for four (4) hours a day, 1:2 during remaining awake hours and 1:2 staff awake coverage over-night;

**Moderate Support Level 2:** Provides support a home with two (2) residents and a direct care staff support ratio of 1:2 for staff awake overnight and 2:2 for eight (8) hours a day, 1:2 during remaining awake hours when

residents are receiving services and adjusted for increased absenteeism from day and employment programs; and

Intensive Support Level 1: Provides support in a home with two (2) residents and a direct care staff support ratio of 1:2 for staff awake overnight and 2:2 for all awake hours when residents are receiving services and adjusted for increased absenteeism from day and employment programs.

Payment for Supported Living is not made for cost of room and board, the cost of home maintenance, upkeep and improvement, modifications or adaptations to a home, or to meet the requirements of the applicable life safety code. Payment for Supported Living does not include payments made, directly or indirectly, to members of the individual's immediate family.

Services are not reimbursed when the individual is receiving Respite.

A 24-hour setting for a single individual is only possible when the individual is a danger to others, as determined by psychological assessment and/or court order. The psychological assessment must be updated on an annual basis to determine the continued necessity for this single 24-hour placement.

The reimbursement rate for Supported Living with Transportation:

Supported Living Rates include:

- (a) All direct support staff and supervision of support staff;
- (b) All nursing oversight provided in the residence for medication administration, physician ordered protocols and procedures, charting, other supports as per physicians orders, and maintenance of Health Management Care Plan;
- (c) Transportation to routine and urgent medical care and to facilitate community access as approved in the ISP;
- (d) Programmatic supplies and fees; and,
- (e) Quality Assurance costs for Incident Management Systems and Staff Development and,
- (f) General and Administrative fees for waiver services.

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

Payments are not made for room and board, the cost of facility maintenance, upkeep, or improvement. The cost of transportation is included in the rate.

Skilled nursing oversight in Supported Living is accounted for in the rate for routine physical assessments, as needed, the development of Health Care Management plans, Nursing assessments, as needed, oversight of non-licensed Medication Administration personnel or LPN's, and/or actual administration of medications. Skilled Nursing may also be authorized as a separate Extended State Plan Service for people who live in Supported Living except supported living with nursing.

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

This service may not be used in conjunction with (same day as) In-home supports, Live-in Caregiver, Host Home, Respite, or Residential Habilitation.

A 24-hour service setting for a single individual is only authorized when the individual is a danger to others, as determined by psychological assessment and/or court order. The psychological assessment must be updated on an annual basis to determine the continued necessity for this single 24-hour placement.

**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 Living

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Supported Living with Transportation**

**Provider Category:**

Agency ▼

**Provider Type:**

Supported Living

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Provider enrolled to provide services through DDS, meets DDS Basic Assurances, and has current Medicaid agreement. For individual employees, the following requirements apply: Documentation that each employee is eighteen (18) years of age or older;

- Documentation that each employee was found acceptable by the individual;
- Annual documentation from a physician or other official that the employee is free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test;
- Record of completion of competency based training in communication with people with intellectual disabilities;
- Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030;
- A high school diploma or general equivalency development;
- Record of completion of competency based training in emergency procedures;
- Certification (annual) in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures; Training needed to address the unique support needs of the individual as detailed in their Plan of Care; and
- Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code, § 54-45.1 et seq.).

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially, and annually thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification



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

**Service Type:**

Other Service ▼

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

**Service Title:**

Supported Living

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

▼

**Category 2:**

**Sub-Category 2:**

▼

**Category 3:**

**Sub-Category 3:**

▼

**Category 4:**

**Sub-Category 4:**

▼

**Service Definition (Scope):**

Note to CMS: Waiver portal will not allow us to select multiple Habilitation Statutory Services. In order to validate and submit this waiver, we changed the Service Type to "Other Service" instead of Habilitation "Statutory Service".

This service is defined as that which provides support to individuals who have limited informal supports and have an assessed need for assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. The home is owned or leased either by the agency or the individual. The Supported Living Service has three categories of each service: Basic, Moderate and Intensive, with two sub-categories of each. Additionally, each category provides services in a home with either one (individualized supports), two (2), or three (3) residents.

The categories are as follows:

- Basic Supported Living 1: Basic Support Level 1 provides asleep overnight support for 3 persons and covers a direct care support ratio of 1:3 during all hours when individuals are awake and receiving services.
- Basic Supported Living 2: Basic Support Level 2 provides awake overnight daily rate support for 3 persons and covers a direct care support ratio of 1:3 for awake overnight, and 1:3 during all awake hours when individuals are receiving services.
- Moderate Supported Living 1: Moderate Support Level 1 provides asleep overnight for 3 persons for a staff support ratio of 2:3 for 8 hours a day, 1:3 during remaining awake hours, and 1:3 asleep coverage when individuals are receiving services.
- Moderate Supported Living 2: Moderate Support Level 2 provides awake overnight with 3 residents for a staff

support ratio of 2:3 for 8 hours a day, 1:3 during remaining awake hours, and 1:3 awake coverage when individuals are receiving services.

- Intensive Supported Living 1: Intensive Support Level 1 with 3 residents covers a direct care support ratio of 1:3 for awake overnight, and 2:3 during all awake hours when individuals are receiving services and adjusted for increased absenteeism from day and employment services.
- Intensive Supported Living 2: Intensive Support Level 2 with 3 residents covers a direct care support ratio of 2:3 for awake overnight, and 2:3 during all awake hours when individuals are receiving services and adjusted for increased absenteeism from day and employment services.

Intensive Individualized Supported Living: Provides intensive individualized staffing at a greater than 1:1 ratio to support a person due to complex behaviors that may involve a serious risk to the health safety or well-being of the person or others, or when required by court order.

Supported Living with Nursing: Provides twenty-four (24) hour supported living services with skilled nursing for people who have a circulatory, respiratory, gastro-intestinal, or neurological condition or any other serious medical condition that requires frequent monitoring or at least hourly care.

Supported Living Periodic: Provides intermittent supported living services to people who demonstrate a need for the acquisition, and improvement of skills related to activities of daily living and the social and adaptive skills necessary for community residence, as indicated in the ISP; and are willing to be supported in their own home or SLR's without twenty four (24) hour supports and supervision.

Basic Support Level 1: Provides asleep overnight support for a home with two (2) residents and a direct care staff support ratio of 1:2 staff asleep overnight coverage and 1:2 staff awake coverage when residents are receiving services;

Basic Support Level 2: Provides overnight support for a home with two (2) residents and a direct care staff support ratio of 1:2 for staff awake overnight and 1:2 during all awake hours when the resident is receiving services.

Moderate Support Level 1: Provides awake overnight daily rate for a home with two (2) residents and a direct care staff support ratio of 2:2 for four (4) hours a day, 1:2 during remaining awake hours and 1:2 staff awake coverage over night

Moderate Support Level 2: Provides support in a home with two (2) residents and a direct care staff support ratio of 1:2 for staff awake overnight and 2:2 for eight (8) hours a day, 1:2 during remaining awake hours when residents are receiving services and adjusted for increased absenteeism from day and employment programs.

Intensive Support Level 1: Provides support in a home with two (2) residents and a direct care staff support ratio of 1:2 for staff awake overnight and 2:2 for all awake hours when residents are receiving services and adjusted for increased absenteeism from day and employment programs.

Payment for Supported Living is not made for cost of room and board, the cost of home maintenance, upkeep and improvement, modifications or adaptations to a home, or to meet the requirements of the applicable life safety code. Payment for Supported Living does not include payments made, directly or indirectly, to members of the individual's immediate family.

A 24-hour setting for a single individual is only possible when the individual is a danger to others, as determined by psychological assessment and/or court order. The psychological assessment must be updated on an annual basis to determine the continued necessity for this single 24-hour placement.

Supported Living Rates include:

- (a) All direct support staff and supervision of support staff;
- (b) All nursing oversight provided in the residence for medication administration, physician ordered protocols and procedures, charting, other supports as per physicians orders, and maintenance of Health Management Care Plan;

- (c) Programmatic supplies and fees;
- (d) Quality Assurance costs for Incident Management Systems and Staff Development; and,
- (e) General and Administrative fees for waiver services.

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

Payments are not made for room and board, the cost of facility maintenance, upkeep, or improvement. The cost of transportation is included in the residential habilitation rate.

Skilled nursing in Supported Living is accounted for in the rate for routine physical assessments, as needed, the development of Health Care Management plans, Nursing assessments, as needed, oversight of non-licensed Medication Administration personnel or LPN's, and/or actual administration of medications. There is no service overlap as Skilled Nursing is not authorized in Supported Living settings as a separate Extended State Plan Service. Skilled Nursing as an Extended State Plan services is only authorized for individuals who live in Host Homes, independently, or in their natural homes. Edits for Supported Living are in the MMIS system to ensure that there is no duplication or overlap of Skilled Nursing services.

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

This service may not be used in conjunction with (same day as) In-home supports, Live-In Caregiver, Host Home, Residential Habilitation, or Personal Care services.

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Supported Living Provider

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Supported Living

**Provider Category:**

Agency ▼

**Provider Type:**

Supported Living Provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

DDS Provider Certification Review per DDS Policy

**Other Standard** (*specify*):

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

agreement.

The providers may also be required to maintain a current Human Care Agreement with DDS for the provision of Residential Services.

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 employee free from communicable disease as confirmed by an annual purified protein derivative of tuberculin (PPD) Skin Test;
- Record of completion of competency based training in communication with people with intellectual disabilities;
- Record of completion of competency based training in infection control procedures consistent with the requirements of the Occupational Safety and Health Administration, U.S. Department of Labor regulations at 29 CFR 1910. 1030;
- A high school diploma or general equivalency development;
- Record of completion of competency based training in emergency procedures;
- Certification (annual) in cardiopulmonary resuscitation (CPR) and First Aid;
- Record of completion of DDS approved pre-service and in-service training in DDS policies and procedures; Training needed to address the unique support needs of the individual as detailed in their Plan of Care; and
- Record of criminal background check consistent with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code, § 54-55.1 et seq.).

#### Verification of Provider Qualifications

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially, and annually thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▼

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

**Service Title:**

Vehicle Modifications

**HCBS Taxonomy:**

**Category 1:**

▼

**Sub-Category 1:**

**Category 2:**

▼

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

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

**Service Definition** (*Scope*):

Vehicle modifications are designed to help the individual function with greater independence. Such adaptations to the vehicle may include a lift or other adaptations to make the vehicle accessible to the individual, or to enable the individual to drive the vehicle. This includes maintenance and repair of vehicle modifications. Excluded are those adaptations which are of general utility or are for maintenance of the vehicle. Car seats are not considered as a vehicle adaptation.

All providers must meet any District requirements for licensure or certification, as well as the person performing the service.

**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. No more than two vehicles can be modified in a five year period. Exceptions may be approved by DDS.

**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	Non-Profit Organization
Agency	Business Entity

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Vehicle Modifications****Provider Category:**Agency **Provider Type:**

Non-Profit Organization

**Provider Qualifications****License** (*specify*):

Have a current license, certification, or registration with the District of Columbia as appropriate for the services being purchased; and comply with all applicable business licensing requirements in the District of Columbia or in the jurisdiction where VM services are provided.

**Certificate** (*specify*):
**Other Standard** (*specify*):

1) Be an enrolled Waiver Provider of Vehicle Modifications and meet any DDS standards; and

2) Demonstrate knowledge in meeting applicable standards of installation, repair, and maintenance of vehicle adaptations and shall also be authorized by the manufacturer to install, repair, and maintain such systems where possible.

**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: Vehicle Modifications**

**Provider Category:**

Agency ▼

**Provider Type:**

Business Entity

**Provider Qualifications**

**License (specify):**

Have a current license, certification, or registration with the District of Columbia as appropriate for the services being purchased; and comply with all applicable business licensing requirements in the District of Columbia or in the jurisdiction where VM services are provided.

**Certificate (specify):**

**Other Standard (specify):**

1) Be an enrolled Waiver Provider of Vehicle Modifications and meet any DDS standards; and

2) Demonstrate knowledge in meeting applicable standards of installation, repair, and maintenance of vehicle adaptations and shall also be authorized by the manufacturer to install, repair, and maintain such systems where possible.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially, and annually thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service ▼

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

**Service Title:**

Wellness Services

**HCBS Taxonomy:**

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

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

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

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

**Service Definition** (*Scope*):

Wellness Services (previously named "Professional Services" in the prior waiver) are direct services to individuals, based on need, and specified in an approved Plan of Care.

Wellness Services offered are:

- 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 individual's independence, participation, emotional well-being and productivity in their home, work and community;
- Provide training or therapy to an individual and/or their natural and formal supports, necessary to either develop critical skills that may be self-managed by the individual or maintained according to the individual's needs;
- Perform assessments and/or re-assessments and recommendations;
- Provide consultative services and recommendations; and
- Provide necessary information to the individual, family, caregivers, and/or team to assist in planning and implementing plans per the approved Plan of Care.

The specific service delivered must be consistent with the scope of the license held by the professional. Service intensity, frequency, and duration will be determined by individual need. The services may be short-term, intermittent, or long-term, depending on the need. The team developing the plan of support makes determinations for service utilization.

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

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

Services are limited to 100 hours per calendar year per service. Requests for additional hours may be approved when accompanied by a physician's order or if the request passes a clinical review by staff designated by the Deputy Director for the Department on Disability Services/Developmental Disabilities Administration to provide oversight on clinical services.

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

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

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

- ☐ Legally Responsible Person  
☐ Relative  
☐ Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Massage Therapist
Individual	Fitness Trainer
Individual	Bereavement Counseling
Individual	Dietetic/Nutrition Counselor
Agency	Home Care Agency
Agency	Sexuality Education

## 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):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially and annually thereafter

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Wellness Services

**Provider Category:**

Individual ▼

**Provider Type:**

Fitness Trainer

**Provider Qualifications**

**License (specify):**

N/A

**Certificate (specify):**

American Fitness Professionals and associates, The Fitness Standards Council (FSC) Personal



Trainer Accreditation

**Other Standard** (*specify*):

Bachelor's level degree in physical education, health education, exercise science, or kinesiology (including Recreational therapist).

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

DDS

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Wellness Services

**Provider Category:**

Individual ▼

**Provider Type:**

Bereavement Counseling

**Provider Qualifications**

**License** (*specify*):

Licensed in accordance with District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 et seq. (2007 Rep. & 2012 Supp.))

**Certificate** (*specify*):

Certified Grief Counselor/American Academy of Grief Counseling

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially, and annually thereafter

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Wellness Services

**Provider Category:**

Individual ▼

**Provider Type:**

Dietetic/Nutrition Counselor

**Provider Qualifications**

**License** (*specify*):

Dietetic and nutrition counselors shall be licensed pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 et seq. (2007 Repl. & 2012 Supp.))

**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS

**Frequency of Verification:**

Initially, and annually thereafter

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Wellness Services****Provider Category:**

Agency

**Provider Type:**

Home Care Agency

**Provider Qualifications****License (specify):**

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

**Certificate (specify):**

**Other Standard (specify):**

**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:**

Agency

**Provider Type:**

Sexuality Education

**Provider Qualifications****License (specify):**

N/A

**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; or

(4) Licensed Professional Counselor

**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: 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.*

- 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, Department on Disability Services (DDS) coordinates case management for individuals receiving ID/DD 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 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 Health Care 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, ÂfÂ,Â,Â§ 44-551 et 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)

- c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:***

- ☐ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- ☒ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

- i. Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Supported Living	
Group Home	

- ii. Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

All residences are located in the community. Rules for these residences require features compatible with the other residences in the surrounding neighborhood. Kitchens, bedrooms, bathrooms and other rooms are like those in a typical homes. Participants have Plans of Care that include recreation and leisure activities and employment consistent with their needs and interests. Each participant must be assured reasonable privacy and adequacy of space, storage, furnishings, bathrooms and other needs. Participants

are encouraged to reflect their personal preferences in decorating and furnishing their individual living spaces. Participants are actively involved in typical, normative daily routines of daily living to the extent of their capabilities including cooking, laundry, shopping and cleaning their rooms.

## Appendix C: Participant Services

### C-2: Facility Specifications

#### Facility Type:

Supported Living

#### Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
In-Home Supports	<input type="checkbox"/>
Behavioral Supports	<input checked="" type="checkbox"/>
Personal Care Services	<input type="checkbox"/>
Skilled Nursing	<input checked="" type="checkbox"/>
Respite	<input checked="" type="checkbox"/>
Physical Therapy	<input checked="" type="checkbox"/>
Personal Emergency Response System (PERS)	<input type="checkbox"/>
Day Habilitation	<input type="checkbox"/>
Vehicle Modifications	<input type="checkbox"/>
Individualized Day Supports	<input type="checkbox"/>
Creative Art Therapies	<input type="checkbox"/>
Supported Living	<input checked="" type="checkbox"/>
One-Time Transitional Services	<input type="checkbox"/>
Wellness Services	<input type="checkbox"/>
Employment Readiness	<input type="checkbox"/>
Companion Services	<input type="checkbox"/>
Small Group Supported Employment	<input type="checkbox"/>
Environmental Accessibilities Adaptations	<input type="checkbox"/>
Supported Living with Transportation	<input checked="" type="checkbox"/>
Speech, Hearing and Language Services	<input checked="" type="checkbox"/>
Host Home	<input type="checkbox"/>
Residential Habilitation	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>
Dental	<input type="checkbox"/>
Family Training	<input type="checkbox"/>

Supported Employment	<input type="checkbox"/>
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**Facility Capacity Limit:**

Three participants

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

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

Group Home, Supervised Apartment, Host Home

**Appendix C: Participant Services****C-2: Facility Specifications****Facility Type:**

Group Home

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
In-Home Supports	<input type="checkbox"/>
Behavioral Supports	<input type="checkbox"/>
Personal Care Services	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>
Respite	<input checked="" type="checkbox"/>

Physical Therapy	<input type="checkbox"/>
Personal Emergency Response System (PERS)	<input type="checkbox"/>
Day Habilitation	<input type="checkbox"/>
Vehicle Modifications	<input type="checkbox"/>
Individualized Day Supports	<input type="checkbox"/>
Creative Art Therapies	<input type="checkbox"/>
Supported Living	<input type="checkbox"/>
One-Time Transitional Services	<input type="checkbox"/>
Wellness Services	<input type="checkbox"/>
Employment Readiness	<input type="checkbox"/>
Companion Services	<input type="checkbox"/>
Small Group Supported Employment	<input type="checkbox"/>
Environmental Accessibilities Adaptations	<input type="checkbox"/>
Supported Living with Transportation	<input type="checkbox"/>
Speech, Hearing and Language Services	<input type="checkbox"/>
Host Home	<input type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>
Dental	<input type="checkbox"/>
Family Training	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>

**Facility Capacity Limit:**

Six participants

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

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>

Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

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

## 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.*

- 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;  
 Personal Care;  
 Host Home;  
 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.

- ☐ **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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

#### a. Methods for Discovery: Qualified Providers

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

##### i. Sub-Assurances:

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

#### Performance Measures

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

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

#### Performance Measure:

**QP.a.i.a.PM.1. Newly enrolled waiver providers meet initial quality and business standards prior to service provision (Number of provider applications that meet standards/Number of new providers that were approved to enroll in the IDD HCBS Waiver program)**

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Provider Database (PRMU-New)

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px;"></div>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

<input type="text"/>		<input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**QP.a.i.a.PM.2. New providers required to pass initial certification within six (6) months of initial delivery of service pass (Number of new providers that received certification to continue to operate within 6 months of initial delivery of services to people in the Waiver/Number of new providers that were approved and initiated delivery of services)**

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**PRMU(new)**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100%</b>

		<b>Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**QP.a.i.a.PM.3. Licensed clinicians continue to meet applicable licensure requirements (Number of licensed clinicians with appropriate credentials/Number of licensed clinicians eligible to provide services)**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**License Database**

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

**Data Aggregation and Analysis:**

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

--	--

**Performance Measure:**

**QP.a.i.a.PM.4. Providers continue to meet applicable certification standards**  
**(Number of providers that continue to meet applicable certification standards/**  
**Number of providers subject to certification)**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Provider Certification Report/Database**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

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

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**QP.a.i.a.PM.5. Providers correct identified deficiencies cited during certification reviews (Number of corrected deficiencies on time/Number of identified deficiencies due to be corrected)**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**MCIS Database**

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**QP.a.i.b.PM.6. Qualified providers of home and vehicle modifications and PERS maintain compliance with waiver requirements. (Number of Providers with current business licenses/Number of enrolled providers of these services)**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**PRMU database- NEW**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:



	<input type="checkbox"/> <b>Other</b> 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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> <b>Other</b> Specify: 	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> <b>Other</b> 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.7. Qualified providers of home and vehicle modifications and PERS maintain compliance with waiver requirements. (Number of Providers with current business licenses/Number of enrolled providers of these services)**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**PRMU database- NEW**

Responsible Party for data collection/generation	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):

<i>(check each that applies):</i>		
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**QP.a.i.b.PM.8. -People receiving Home and Vehicle modifications and PERS**

services report satisfaction with providers of Home and Vehicle modifications and PERS services. Number of people who reported satisfaction with providers/Number of people who received Home and Vehicle Modifications and PERS services and responded to the satisfaction survey.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Satisfaction Survey A, A-NEW**

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

**Data Aggregation and Analysis:**

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

<input type="text"/>	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>

- 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.9. Certified providers train staff according to DDS policies and procedures (Number of providers that meet all training indicators on the PCR/Number of providers reviewed through certification)**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Certification Database**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:

	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

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

QP.a.i.a.PM.1. Newly enrolled waiver providers meet initial quality and business standards prior to service provision (Number of provider applications that meet standards/Number of new providers that were approved to enroll in the IDD Waiver program)

Providers that have not previously been certified for any services by DDS will be subject to "pre-qualification" requirements conducted by the Provider Resource Management Unit (PRMU) 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 PRMU 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)

PRMU 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.b.PM.7. Qualified providers of home and vehicle modifications and PERS maintain compliance with waiver requirements (Number of Providers with current business licenses/Number of enrolled providers of these services)

The PRMU verifies the business licenses for all home and vehicle modification and PERS providers at least annually. A provider who does not maintain current business licenses will be suspended from the HCBS waiver program.

If a provider fails to provide evidence that it meets the licensure requirements within thirty (30) days of request, DDS will notify the provider and DHCF to initiate the process for termination of the Medicaid Agreement.

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.a.PM.5. Providers continue to meet applicable certification standards (Number of providers that continue to meet applicable certification standards/ Number of providers subject to certification)

QP.a.i.c.PM.9. Certified providers train staff according to DDS training policy and procedure (Number of providers that meet training indicators in the PCR/Number of providers reviewed through certification)

The PCR Team monitors providers of direct services and evaluates providers based upon a set of key domains. Providers of residential habilitation, supported living, in-home, host-home, respite, supported employment, day habilitation, individualized day, and employment readiness are subject to on site reviews annually. This review includes a random sample of individuals served by the provider and is representative of the types of services and supports provided. In addition, an organizational review is conducted to assure that the agency is positioned to support quality across all its services and supports. The organizational review includes a thorough review of the systems to protect and promote rights, mitigate risks, ensure that staff is qualified and competent, and ensure that service delivery supports independence, skills acquisition and quality management strategies. PCR Team observe individuals on site, interview individuals, family members and key staff, and review documentation. Each provider is reviewed every year, at a minimum.

Providers that fail to meet the standards of the Provider Certification Review are referred to DHCF with a recommendation for termination from the I/DD HCBS waiver program. Providers that fail to maintain individual Residential Habilitation home licensure by the Department of Health are placed on enhanced monitoring for all Residential Habilitation services by DDS until a plan of correction is successfully met.

Aggregated findings by performance domain areas are summarized and reported monthly to the DDS Quality Management Director. The DDS Quality Management Division (QMD) 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).

PRMU and QMD conduct remediation activities as outlined in the waiver application to ensure providers correct any deficiencies cited during any PCR activity.

QP.a.i.b.PM.8. Waiver individuals report satisfaction with providers of Home and Vehicle modifications and PERS services (Satisfaction ratings of individuals who have used these services)

DDS is developing a survey to measure the satisfaction of waiver individuals who used qualified providers of Home and Vehicle modifications and PERS. The survey will be administered at least annually and for each person who has used this service. The results will be aggregated by provider and reviewed annually by the QIC for any remediation/improvement recommendations as appropriate.

## **b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

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 are monitored 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( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. **Timelines**

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

☐ No

☒ Yes

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

Develop a database for licensed clinicians, home and vehicle modification, PERS providers, and Provider Resource Management Unit, by January 2013.

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 cliniciantherapy they are licensed to provide, the date of their licenses issuance and the expiration.

Develop and implement a satisfaction survey for users of home and vehicle modification, PERS services by January 2013. Develop and implement a satisfaction survey for users of home and vehicle modifications and PERS services by January 31, 2013.

1. Research satisfaction surveys by November 30, 2012.
2. Develop survey and methods by December 31, 2012.
3. Train staff to administer survey by January 15, 2013.

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

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

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

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

- ☒ **Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ☐ **Applicable -** The State imposes additional limits on the amount of waiver services.

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

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

- ☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.  
*Furnish the information specified above.*

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

- ☐ **Other Type of Limit.** The State employs another type of limit.  
*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

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

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



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

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

DC is confident that many of our service settings already meet the definition of home and community based settings, however, as part of our transition planning, we will review all settings to ensure compliance with the CMS rule and guidance. As examples, our supported living and host home services consist of small apartments and homes in the community; likewise, individualized day and supported employment services are integrated and community based. Our larger day habilitation settings will likely require changes to meet the new definition. In recognition of that concern, one of our waiver amendments is to add a new small group rate for day habilitation, although we recognize that other changes may be required as well. Likewise, our larger employment readiness services raise concerns around compliance with the definition. As part of our planning for the future, DDS plans to review all of our regulatory and certification requirements and monitoring tools to ensure that our requirements align with the definition of home and community based settings and related guidance.

## 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 two years of 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 ID/DD 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 Service Coordinator in SPCD will discuss the HCBS Waiver program with the individual and offer them the choice of ICF or HCBS Waiver. The LON is updated by the Service Coordinators and a Level of Care (LOC) is completed. Upon being determined eligible for waiver services, the individual's assigned Service Coordinator in SPCD explains all available services in the Waiver. The individual and his/her family or legal representatives can then make informed choices.

The individuals are also informed of all procedural safeguards, their rights and responsibilities, how to request a change of providers, and the District's grievance and complaint procedures.

The ISP/ Plan of Care is developed through a collaborative support team process involving the individual, family, friends or other support systems, legal representatives, the Service Coordinator, appropriate professionals/service providers, and others who the individual chooses to be involved.

Prior to the initial or annual ISP/ Plan of Care (POC) meeting, the Service Coordinator meets with the individual (and their family/legal representatives, as appropriate). The meeting is conducted face-to-face in the individual's location of choice or the offices of the Department on Disability Services, depending on which is more convenient. During this visit, the individual chooses who will be part of his/her planning process as their team. The Service Coordinator assists the individual in contacting the team members with the date, location and time of the meeting. Additionally, for the annual ISP/POC, this meeting is used to assist the individual in reviewing his/her progress in meeting the previous year's goals. The individual'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 this meeting and more frequently as needed, should a situation arise mid-cycle during the Plan of Care 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 Care. A standardized person-centered planning format is used throughout the ISP/Plan of Care development process.

The individual 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 individual, their family/legal representatives (as appropriate), the Service Coordinator and others invited by the individual. These team members know and work with the individual and their active involvement is necessary to achieve the outcomes desired by the individual.

## 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):

(a) The ISP/Plan of Care process assures that individuals have access to quality services and supports that foster:

- Independence, learning and growth;
- Choices in everyday life;
- Meaningful relationships with family, friends and neighbors;
- Presence and participation in the fabric of community life;
- Dignity and respect;
- Positive approaches aimed at skill development; and
- Health and safety.

The ISP/Plan of Care process is driven by the individual's vision, goals, and needs with overall management and facilitation provided by the Service Coordinator.

The ISP/ Plan of Care is developed through a collaborative support team process involving the individual, family, friends or other support systems, legal representatives, the Service Coordinator, appropriate professionals/service providers, and others who the individual chooses to be involved. The plan must be completed within ninety (90) calendar days of the enrollment in the ID/DD HCBS Waiver.

Prior to the annual ISP meeting, the DDA Service Coordinator initiates the creation or updating of a Level of Need (LON) tool, notifies the appropriate team members when the tool is in the main consumer information system (MCIS) so that other team members may add necessary information and so that the Service Coordinator can then complete the tool.

An individual who is newly eligible to DDA services has an initial LON completed by the Intake and Eligibility Determination Unit. Upon transfer to the SPCD and election by the individual to participate in the HCBS Waiver program the LON is updated by the Service Coordinator and the LOC is completed by a QDOP.

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 Care. The supervisor is responsible for ensuring that the waiver services are clearly delineated and justified based upon the needs identified in the Plan of Care and its accompanying assessments. The ISP/Plan of Care is implemented within thirty (30) days of the Plan of Care meeting. Annually, the entire team meets to review and revise the plan for the upcoming service year.

(b) The types of assessments conducted to support the service plan development process include personal interviews, and initial assessments 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 assessments include psychological evaluations, medical evaluations, a social history derived from the intake and a LON. The initial assessment processes may also use other standardized assessment tools, including Health Care Forms and a health risk screening tool, to assist in ensuring that the individual's health and safety needs are met. Additional information for the assessment process is collected by the Service Coordinator and includes the following information:

- 1) The personal outcomes envisioned, defined and prioritized by the individual;
- 2) Medical/physical information and documentation;
- 3) Psych-social/behavioral information;
- 4) Developmental/intellectual information and documentation;
- 5) Socialization/recreational information and documentation, including relationships that are important to the individual and the social environment of the individual;
- 6) Patterns of the individual's everyday life;

- 7) Identification of informal supports available to the individual;
- 8) Information and documentation on financial resources;
- 9) Educational/vocational information and documentation;
- 10) Information on the current status of housing and the physical environment;
- 11) Information about previously successful and unsuccessful strategies to achieve the individual's desired personal outcomes;
- 12) Safeguards for protection from harm; and
- 13) Any other information relevant to understanding the supports and services needed by the individual to achieve the desired personal outcomes.

A reassessment may be conducted at any time, particularly when a significant change in the individual'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 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 screenings or assessment tools that have been completed.

(c) Individuals and their legal representatives are informed of available 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.

(d) The plan development process ensures that the service plan addresses participant goals, needs, and preferences by identifying the individual's prioritized personal outcomes, and specific strategies to 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 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 providers 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 Care. The requirement of this information and its inclusion in the Plan of Care ensures the individual's goals, needs, including health care needs and preferences are appropriately addressed.

(e) 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 MCIS system and is reviewed by the Service Coordinator's supervisor. Any concerns are addressed by the supervisor.

(f) The plan development process provides for the assignment of responsibilities to implement and monitor the plan as follows:

The individuals and their legal representatives are encouraged to contact the Service Coordinator at any time for assistance. Formal 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 a 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 to the identified services and supports that are outside of the Medicaid-funded services. During monthly contacts with 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 individual chooses to be present, review the Plan of Care to determine if the goals identified in the ISP/Plan 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.

(g) 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 individual'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 Care. The Service Coordinator is solely responsible for ensuring that the Plan of Care is conducted in accordance with DDS requirements and is consistent with best practices in the field of developmental disabilities. Mid Plan of Care cycle changes that require ISP/ Plan of Care revisions 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 beginning in December of 2011, for all individuals. 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 of the initial Individual Support Plan meetings and be updated as needed at the time.

During the planning process, team members discuss possible strategies to mitigate potential risks that have been identified. Development of strategies to mitigate risks shall take into account the needs and preferences of the individual. The approaches utilized to mitigate each specific risk are incorporated into the Plan of Care.

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 individual, 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 individual's informal support system as a means of meeting the individual's back-up plan unless the individual, with assistance from their team, has agreed to do so. This agreement must be documented in the Plan of Care.

The Service Coordinator assists the individual and the team members in identifying individuals who are willing and able to provide a back-up system during times when paid supports are not scheduled in the individual's Plan of Care.

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-of-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 outlining how and when the direct support staff are to be trained in the care and supports needed by the

individual 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 individuals and their legal representatives are informed of the services available under the waiver during the Service Coordinator's initial planning meeting with the individual. 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 individual and their legal representatives also discuss the role of the Service Coordinator and determine the support that the individual requires from the Service Planning and Coordination Division.

The Service Coordinator provides the individual with a list of all qualified Medicaid providers and the specific waiver services they offer. The individuals 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 individual in contacting and interviewing potential providers. The Service Coordinator also has the responsibility of assisting the individuals when they wish to change providers.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Authorities to approve individual centered plans are delegated to DDS, the operating agency. DHCF staff will participate in one Individual Service Plan meeting during the year and review 10% of DDS ISP Quality Review samples to monitor waiver assurance and compliance of the Memorandum of Understanding (MOU) 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 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 individuals to the identified services and supports that are outside of the Medicaid-funded services. During monthly contacts with 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.
- Every six (6) months, or more frequently as needed, the Service Coordinator, the individual, the service provider(s), and others that the individual chooses to be present, review the Plan of Care to determine if the goals identified in the ISP/Plan are being achieved, review the individual's needs, including health and safety to ensure identified needs are being addressed, and to make any adjustments or changes necessary to the Plan.
- Service Coordinator supervisors review a sample of ISP's of each of the Service Coordinators who 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), 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.
- 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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

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

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

##### i. Sub-Assurances:

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

#### Performance Measures

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

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

#### Performance Measure:

**SP.a.i.a.PM.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 have an annual ISP completed during the reporting period)**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**MCIS**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative



		<b>Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**SP.a.i.a.PM.2. Individual Support Plans reflect personal goals and needs identified through the LON assessment process. (Number of service plans that address personal goals and needs identified during the LON assessment process/Number of service plans reviewed.)**

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**ISP Quality Review-MCIS**

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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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 28% (35 ISP Quality Reviews are completed each month for a total of 105 per quarter or 420 annually)
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
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- 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.*

### Performance Measure:

**SP.a.i.b.PM.1. Each individual's initial ISP is completed by the service coordinator and submitted to the DDA Waiver Unit within 90 days of enrollment in the ID/DD HCBS Waiver. (Initial ISPs for waiver participants submitted on time/total initial ISPs for new IDD HCBS waiver participants due)**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**MCIS**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:

		<input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**SP.a.i.b.PM.2.** Each individual's annual ISP is completed by the service coordinator and submitted in accordance with established timelines prior to the service expiration date to the waiver unit for service re-authorization. (Annual ISPs submitted on time/annual ISPs renewals due)

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**MCIS**

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

		<input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

- c. **Sub-assurance:** Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's 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.1. Annual ISPs are approved on time within 365 days (Annual ISPs approved on time/ISPs due)**

**Data Source (Select one):**

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

**MCIS**

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

**Data Aggregation and Analysis:**

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

<input type="text"/>	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**Performance Measure:**

**SP.a.i.c.PM.2.** ISPs are revised in response to the person's request, change in needs and change in supports (Number of people who had revised ISP/Number of people who requested and/or experienced a change in needs and/or supports)

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**ISP Quality Review-MCIS**

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):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 28% (35 ISP Quality Reviews are completed each month for a total of 105 per quarter or 420 annually)
	<input type="checkbox"/> <b>Other</b> Specify:	

	<input type="text"/>
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**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM3. Percentage of DDS Service Coordination staff trained on ISP development and management of services in accordance with the State requirements and the approved waiver. N=Number of service coordinators trained in ISP development and management /D= Total number of DDS service coordinators responsible to develop and manage ISPs.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

**DHCF reviews the Individualized Service Plans developed by the DDS Service Coordinators**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>



<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: DHCF will review a random sample of no more than 10 staff per quarter and will analyze data quarterly

**Performance Measure:**

**PM 4. Percentage of ISPs that meet standards contained in DDS training:**  
**N=Number of waiver participants whose ISP complies with training standards/D=Total number of ISPs reviewed.**

**Data Source (Select one):****Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>

<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: DHCF will review 30 participants' records per quarter and will analyze data quarterly.

- 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. Individuals receive services described in their ISP in type, scope, amount, duration, and frequency as specified in the ISP. (Number of individuals that receive services as described in the ISP in type, scope, amount, duration and frequency/ total number of individuals received service coordination monitoring visits)**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Day and Residential Monitoring Tools-MCIS**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data	Frequency of data aggregation and

<b>aggregation and analysis</b> (check each that applies):	<b>analysis</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- e. *Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and 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. The ISP includes documentation that the individual was given a choice of services and service providers (Number of ISPs reviewed that include documentation/Number of ISPs reviewed)**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**ISP Quality Review-MCIS**

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

		Interval = <div> <div></div> <div></div> </div>
<input type="checkbox"/> <b>Other</b> Specify: <div> <div></div> <div></div> </div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div> <div></div> <div></div> </div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 28% (35 ISP Quality Reviews are completed each month for a total of 105 per quarter or 420 annually)
	<input type="checkbox"/> <b>Other</b> Specify: <div> <div></div> <div></div> </div>	

**Data Aggregation and Analysis:**

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

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

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.a.PM.2. ISPs reflect personal goals and needs identified through the LON assessment process. (Number of service plans that address personal goals and needs identified during the LON assessment process/Number of service plans reviewed.)

SP.a.i.c.PM.2. ISPs are revised in response to the person's request, change in needs and change in supports (Number of people who had revised ISP/Number of people who requested and/or experienced a change in needs and/or supports)

SP.a.i.e.PM.2. ISP includes documentation that the person was given a choice of services and service providers (Number of ISPs reviewed that include documentation/Number of ISPs 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.a.PM.1. the Level of Need (LON) assessment is completed 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 ISP)

SP.a.i.b.PM.1. ISP is completed by the service coordinator and submitted to the waiver unit within 90 days of enrollment in the IDD HCBS Waiver (ISPs submitted on time/ISPs due)

SP.a.i.b.PM.2. A annual ISP is completed by the service coordinator and submitted in accordance with established timelines prior to the service expiration date to the waiver unit for service re-authorization. (Annual ISPs submitted on time/annual ISPs renewals due)

SP.a.i.c.PM.1. Annual ISPs are approved on time (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.d.PM.1. People receive the services described in their ISP in type, scope, amount, duration, and frequency as specified in the ISP. (Number of people whose s were determined to be receiving services by Service Coordinator monitorings/Number of monitoring visits completed by Service Coordinators)

Service Coordinators are responsible for monitoring waiver service provision as defined in policies and procedures. When the person is not receiving the services identified, the Service Coordinator can sometimes immediately correct the issue or may enter it is an issue to which the provider must respond and the assigned staff monitors to closure. The aggregated monitoring tool results are analyzed quarterly for patterns with providers and/or services to identify systems improvement activities.

## **b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. 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( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually  <input type="checkbox"/> Continuously and Ongoing  <input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

## c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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

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**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

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**E-1: Overview (1 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services****E-1: Overview (2 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services****E-1: Overview (3 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services****E-1: Overview (4 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services****E-1: Overview (5 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services****E-1: Overview (6 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services****E-1: Overview (7 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services****E-1: Overview (8 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services****E-1: Overview (9 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services****E-1: Overview (10 of 13)**



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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (11 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (12 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (13 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Official introduction to the HCBS waiver program is provided by the DDS Service Coordination and Planning Division. This includes information on the choice between ICF and the HCBS Waiver program. Individuals interested in the DDS/DDA waiver receive information from the assigned DDA Service Coordinator on how to access the DDS provider information from the DDS website, as well as information about the HCBS waiver services. At that time, information regarding the fair hearing process is also provided, including grounds for an appeal, such as denial of a service and disputes that are not reconciled through dialogue with the DDS waiver provider or with DDS. DDS notifies ID/DD 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 ID/DD waiver-funded service authorized on the participant's ISP, (4) the participant is denied his or her choice of qualified ID/DD waiver provider(s), or (5) a decision or action is taken to deny, suspend, reduce or terminate the participant's Medicaid eligibility. The Economic Security Administration (ESA) determines eligibility for ID/DD waiver services, 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 ID/DD 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 case manager 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/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.

**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 Policy", and cross referenced procedures apply to every individual served by DDA and the DDA service providers and outlines the method for individuals to file a complaint and seek informal resolution regarding the services of DDA and the service provider.

a) The types of complaints include, but are not limited to, allegations of a violation of a person's rights, dissatisfaction with the DDA service coordinator, the Individual Support Plan or delivery of supports and services, allegations of denial, delay or suspension, termination or reduction in services, access to records, denial of choice in service providers or any other dissatisfaction relating to rights, supports or services. A denial or termination of eligibility will not be considered through this complaint process.

b) Complaints must be filed within ninety (90) days of the alleged incident with exceptions for individuals who lack capacity to exercise the right or individuals who initially participated in a provider complaint process. Attempts will be to resolve the complaint using an informal dispute resolution process within five (5) days. If the informal process is not successful, an alternate dispute resolution process will be implemented to resolve the issue within 30 days of the filing. If the alternate dispute resolution is not successful the complaint may be referred to the Deputy Director for DDA for final DDA resolution. This policy does not preclude the filing of a request for administrative hearing with OAH.

## 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. Verbal 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 conducting an on-site visit within two (2) business days of acceptance by the IRC of an SRI excluding a death. If the individual's residence or service location is outside of the District of Columbia metro area, the person lives independently or with a family (natural home), or if there are extraordinary circumstances such as severe weather, the on-site visit does not apply. In the event of an exception, the Service Coordinator makes contact via the telephone or email also within two (2) business days. 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 verbally 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 Management Division 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 annually at the ISP, 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 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 committee member representing Service Coordination and/or 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 an on-site visit within two (2) business days of a SRI excluding death, unless the individual's residence or service location is outside of the District of Columbia metro area, the person lives independently or with a family (natural home), or if there are extraordinary circumstances such as severe weather. In the event of an exception, the Service Coordinator makes contact via the telephone or email within two (2) business days. 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 on-site visit within the next business day of being accepted by the IRC. For all other SRIs except death, the IMEU investigator contacts the provider by telephone to verify or recommend actions to promote the individual's safety within the next business day.

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.

All provider and DDS Investigators assigned to conduct investigations of SRIs must complete and pass a 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 identify patterns for individuals and/or providers. If the committee becomes aware of a pattern, the IRC Facilitator will enter an incident or issue. If the committee suspects there is a pattern, the IRC Facilitator or designee will research the concern and report back to the IRC. If there is an incident or issue, the IRC Facilitator will enter in accordance with the established policies and procedures for incident and issue management.

The IRC Core Team meets bi-weekly to review data obtained over the past three (3) months to include frequency, types of incidents, unmet needs, domains and sub-domains for issues, repeated issues, and other variables to identify individual and/or provider patterns or trends. If the committee becomes aware of a pattern, the IRC Facilitator will enter an incident or issue. If the committee suspects there is a pattern, the IRC Facilitator or designee will research the concern and report back to the IRC. If there is an incident or issue, the IRC Facilitator will act in accordance with the established policies and procedures for incident and issue management.

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 incident management. The quarterly report is submitted to DHCF.

Data is 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 bi-annual 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 people receiving waiver services who have a behavior support plan developed by an ISP team which 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, 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.

Additional responses based on CMS' questions during informal RAI-

Methods for detecting unauthorized use, over use or inappropriate/ineffective use of restraints or seclusion and ensuring that all applicable state requirements are followed?

During routine monitoring by Service Coordinators which occurs at least four times per year (one time per quarter) for each person receiving waiver services, the Service Coordinator meets with the person, the staff and reviews documentation to detect unauthorized use of restraints or seclusion or overuse of approved restraints. Seclusion is not allowed and therefore, any use would be unauthorized. Any unauthorized use of restraint or seclusion would result in an incident of inappropriate use of restraint or neglect. All allegations of neglect are investigated by DDA's IMEU (Incident Management and Enforcement Unit) Investigators.

Health Care Review Summaries are completed by Health and Wellness Specialists. The Health and Wellness Supervisor determines the number of reviews to be completed each fiscal year. In FY2013, Health and Wellness Specialists will complete a review of 25% of the people who receive residential services (including ICF/IDD) by provider. 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 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 there are any outstanding issues, the issue is entered and assigned to the appropriate DDA staff for follow-up.

How data are analyzed to identify trends and patterns and support improvement strategies?

Data from the Service Coordination monitoring, the Health Care Review Summaries, PCR reviews, and from incident reports are reviewed at least quarterly by the Quality Management Division 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 monthly, quarterly and 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 Director of the Quality Management Division for improvement.



The Quality Management Division (QMD) compiles a quarterly report 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 QMD compiles a quarterly report of Service Coordination monitoring tools to identify patterns or trends within the service delivery system. The quarterly report is reviewed by the QIC who is charged with making recommendations for improvement. The QIC reviews data from all the reports and data to make recommendations for quality improvement initiatives.

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 Management Division 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 provider
- o By funding source (Waiver/Non-Waiver)
- o Reporting on time
- o Investigation Outcomes for SRIs
- o Recommendations
- o Recommendations for further action

The report is 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 the Quality Management Division.

- 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. 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 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 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.

## 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 ID/DD 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 of relevant factors that may influence the target behavior, including but not limited to medical/psychiatric, social, environmental and communication factors; functional assessment of the target behaviors; description of alternative behaviors and replacement skills, and training requirements specific to the behavior support plan. The Behavior Support Plan must describe the use of any restrictive interventions and a plan for reducing, fading or eliminating the use of restrictive interventions. The Behavior Support Plan must provide a rationale for the use of the restrictive intervention including the determination that the restrictive interventions were reviewed against the

dangers of the behavior and the restrictiveness of the intervention. There must be sufficient behavior data to demonstrate the need and the effectiveness of the restrictive intervention.

The Behavior Support Procedure also details the requirements when medication is used as sedation prior to medical appointments. A desensitization plan is required unless it is clinically determined that such a plan is ineffective. The use of medication as a sedation requires the same safeguards and approvals as any other restrictive intervention.

The person and/or legal guardian must give informed consent for the use of all restrictive components of the Behavior Support Procedure. Consent must be given by someone legally authorized to do so under District of Columbia laws. Prior to implementation of the BSP which includes restrictive interventions, the BSP must be reviewed and approved by the ISP Team, the provider's human rights committee and the DDS Restrictive Control Review Committee.

Additional answers based on CMS' informal RAI-

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. In FY2013, Health and Wellness Specialists will complete a review of 25% of the people who receive residential services (including ICF/IDD) by provider. 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 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 there are any outstanding issues, the issue is entered and assigned to appropriate DDA staff for follow-up.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DDS uses information gathered through the Restrictive Control Review Committee (RCRC), service coordination monitoring, health and wellness monitoring, and incident management system to monitor the effectiveness of the system to ensure that all behavior support plans have been reviewed and approved by the appropriate people and committees.

Service Coordinators conduct monitoring at least once each quarter. Health and Wellness staff conducts periodic monitoring as assigned to measure the system's effectiveness. The Provider Certification Team ensures that providers subject to PCR are following the DDS policies and procedures. When there are individual or provider concerns, the issues are reported through the Issue Resolution System in MCIS and tracked to resolution.

The RCRC reviews all behavior support plans that include restrictive controls to ensure that the behavior support plan was developed in accordance with the policies and procedures of DDS. It is not approved unless there is evidence that the plan contains all required components including consent and review by the provider human rights committee. When there are individual or provider issues the Rights and Advocacy Specialist who chairs the RCRC committee follows the Immediate Response Committee policy to document issues that are tracked to resolution.

Each quarter, the Quality 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.

Additional answers based on CMS' informal RAI-

. 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?

Response

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<sup>TM</sup> incident management system. DHCF's Division of Special Needs 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<sup>TM</sup>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, Division of Special Needs 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<sup>TM</sup>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 (what time period?). This Form was recently 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<sup>TM</sup>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-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:

☐ **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.

Additional answers based on CMS' informal RAI-

#### 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. In FY2013, Health and Wellness Specialists will complete a review of 25% of the people who receive residential services (including ICF/IDD) by provider. 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 Provider Resource Management Unit (PRMU) holds a Provider Performance Review (PPR). The PRMU solicits input from Service Coordination, Health and Wellness, and Provider Certification Review (PCR) from the results of monitoring. The Quality Management Division (QMD) 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 Improvement Unit reviews the licensing report and enters any

issues for follow up into the Issue Resolution System for tracking and follow up.

Through the quarterly review of incident management data, DDS analyzes the occurrence of medication errors and reports patterns or trends to the Quality Improvement Committee for recommendations to the DDS Deputy Director of DDA.

Additional answers based on CMS's informal RAI-

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 Special Needs 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.

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 I 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 may 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 may 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.

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 may 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.

Bi-weekly, the IRC Core Team meets to review data for the past three (3) months to include frequency and types of medication errors to identify individual and/or provider patterns or trends. If the committee becomes

aware of a pattern or suspects a pattern, the IRC Facilitator will enter an incident or issue. If the committee suspects there is a pattern, the IRC Facilitator or designee will 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.

Data is reviewed by the DDA Quality Improvement Committee that makes recommendations to the DDS Deputy Director for DDA, for providers and/or systemic follow up.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

#### a. Methods for Discovery: Health and Welfare

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

##### i. Sub-Assurances:

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

#### Performance Measures

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

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

#### Performance Measure:

**Percentage of all serious reportable incidents reported according to time frames outlined in DDSA's Incident Management procedure. Numerator: number of serious reportable incidents reported timely. Denominator: Total number of serious reportable incidents reported.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**MCIS**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div><div></div><div></div></div>
<input type="checkbox"/> Other Specify: <div><div></div><div></div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div><div></div><div></div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div><div></div><div></div></div>
	<input checked="" type="checkbox"/> Other Specify: Bi-Weekly	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div><div></div><div></div></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div><div></div><div></div></div>

**Performance Measure:**

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**

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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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Less than 100% (not to exceed 30 records)
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**MCIS**

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: DHCF will reviews 30 incidents or less through MCIS quarterly.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

<input type="checkbox"/> <b>Continuously and Ongoing</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**Performance Measure:**

Percentage of allegation of abuse, neglect and serious physical injury incidents receiving timely follow up by IMEU, according to incident management policies and procedure. Numerator: number of allegations of abuse or neglect and serious physical injuries receiving timely follow up. Denominator: number of allegations of abuse or neglect and serious physical injuries accepted by DDS.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**MCIS/Investigation Reports**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Less than 100% (not to exceed 30 incidents or less)
	<input type="checkbox"/> <b>Other</b> Specify:	

	<input type="text"/>
--	----------------------

**Data Aggregation and Analysis:**

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

**Performance Measure:**

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**

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe

<input type="text"/>		Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Less than 100% (not to exceed 30 investigations)
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Percentage of investigations with indication of people being notified timely of investigation outcome. Numerator: number of incident investigations of allegations of abuse or neglect with notification to the person or representative of outcome within five (5) business days of provider receiving investigation report/Denominator: number of DDS incident investigations completed/closed.**

**Data Source (Select one):****Other**

If 'Other' is selected, specify:

**DDS Report**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>



<b>Agency</b>		
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: DHCF will review 30 investigations or less through DDS Reports on a quarterly basis.
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

b. *Sub-assurance: The state demonstrates that an incident management system is in place that*

*effectively resolves those incidents and prevents further similar incidents to the extent possible.*

### Performance Measures

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

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

#### Performance Measure:

**Percentage of investigation recommendations implemented according to Incident management Policies and Procedures N= No. of investigation recommendations implemented timely/ D= No. of investigations recommendations made for incidents that occurred during the previous quarter.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

**MCIS**

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: DHCF will review 30 incident investigations through MCIS quarterly.
	<input type="checkbox"/> Other Specify:	

	<input type="text"/>
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**Data Aggregation and Analysis:**

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

**Performance Measure:**

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. No of death investigations completed within 45 days of submission of the complete record/ No. of death investigations due to the MRC that quarter.

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

<input type="text"/>		<input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Percentage of MRC recommendations responded to with a plan of correction within 15 business days of receipt of the recommendations, as outlined in the DDS mortality review committee policies and procedures. N= No. of recommendations responded to with a plan of correction within 15 business days/ No. of accepted MRC recommendations due to receive a plan of correction that quarter.

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**MCIS**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100%</b>

		<b>Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Percentage of death investigations reviewed by the Mortality Review Committee within 45 days of the receipts of the death investigation report N= No. of death incidents reviewed by MRC within 45 days of the receipt of the completed investigation/ No. of death investigations due to be reviewed that quarter.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**MCIS**

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

**Data Aggregation and Analysis:**

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

	<input type="text"/>
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**Performance Measure:**

**Number and percent of death investigations where recommended actions to protect health and welfare are implemented. No. of MRC recommendations implemented timely/No. of MRC recommendations due during the quarter.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Death investigation reports**

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

**Data Aggregation and Analysis:**

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

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Percentage of Fatality Review Committee (FRC) recommendations made to DDS that were implemented within the assigned time frame. No. of FRC recommendations implemented within assigned timeframe/No. of FRC recommendations due that quarter.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**MCIS**

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



**Data Aggregation and Analysis:**

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

- c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

**Performance Measures**

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

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

**Performance Measure:**

**Number and percent of approved BSPs with restrictive interventions that meet standards outlined in DDS' policies and procedures. Number of behavior support plans that met the standards as outlined in the DDS's RCRC procedure/Number of BSP's with restrictive measures approved by the Restrictive Controls Review Committee (RCRC) during the quarter.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**MMIS**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: DHCF will review 15 records per quarter.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Percentage of people receiving psychotropic medications who had quarterly medication reviews. Number of people who had a timely medication review/Number of people scheduled for psychotropic medication review.

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: DHCF will review not more than 15 records quarterly.
	<input type="checkbox"/> Other Specify: <input type="text"/>	

## Data Aggregation and Analysis:

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

	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="text-align: right;"> <span>⬆</span>  <span>⬇</span> </div>
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**Performance Measure:**

**Percentage of Behavior Support Plans (BSP) containing restrictive measures reviewed by the RCRC. Number of BSPs with restrictive measures reviewed by RCRC/Number of BSPs with restrictive measures.**

**Data Source (Select one):****Other**

If 'Other' is selected, specify:

**MCIS**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="text-align: right;"> <span>⬆</span>  <span>⬇</span> </div>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="text-align: right;"> <span>⬆</span>  <span>⬇</span> </div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="text-align: right;"> <span>⬆</span>  <span>⬇</span> </div>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="text-align: right;"> <span>⬆</span>  <span>⬇</span> </div>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="text-align: right;"> <span>⬆</span>  <span>⬇</span> </div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number and percent of unauthorized uses of restrictive interventions that were appropriately reported according to incident management policies and procedures.  
Number of unauthorized uses of restrictive interventions appropriately reported/Number of unauthorized uses of restrictive interventions reported during the quarter.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**MCIS**

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

	<input type="text"/>
--	----------------------

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Medications that are not self-administered by appropriately credentialed staff.  
Number of providers who meet the PCR indicator for administration by trained staff/Number of providers for whom that indicator is applicable.

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

<input type="text"/>		<input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

There are no additional performance measures

**Data Source** (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

N/A

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

		Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> <b>Other</b> Specify: N/A	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: N/A	

**Data Aggregation and Analysis:**

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

- 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:**



**Number and percent of waiver participants who received physical exams in accordance with state waiver policies. Number of participants who have had a physical exam in the last 12 months/Number of people who receive a Residential Monitoring review during the review period.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Residential Monitoring Tools**

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

**Data Aggregation and Analysis:**

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

<input type="text"/>	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

Percentage of issues in MCIS issue resolution system or its replacement remediated according to DDS issue resolution policies and procedures. Number of issues remediated within IRC assigned time frame/Number of issues accepted by DDS in the previous quarter.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**MCIS**

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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: DCHF will review 5% of issues through MCIS (or a replacement system).
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

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

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

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 the DHCF Continuing Care for Persons with Special Needs (Long Term Care Division) Branch and the Division of Quality and Health Outcomes. Within the Continuing Care for Persons with Special Needs Branch there are designated staff assigned to 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, the Continuing Care for Persons with Special Needs (Long Term Care Division) Branch will analyze the data for individual and systemic concerns.

In addition to DDS submitting data, DHCF will have ongoing access to the DDS, MCIS system. As needed, and within frequencies identified in each performance measure, DHCF will access MCIS to cross reference data submitted by DDS. Findings to this data will be reported to DDS in a quarterly report. Additionally, identified discrepant information will also be included in DHCF's quarterly submission to DDS. Discussion of the findings and discrepant information will occur during monthly DHCF/DDS quality management committee meetings.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. 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 monthly 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( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 2)

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;
- 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 2)

### 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 you've 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 District's 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 DHCF's 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. 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 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.

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. University Legal Services (ULS) serves as the protection and advocacy agency and periodically conducts monitoring activities for people receiving waiver services. The District, as a part of the Evans vs. Gray settlement, experiences periodic monitoring by the court monitor. The court monitor conducts reviews of the services provided to Evans class members. Some class members receive waiver services. The Quality Trust for People with Intellectual Disabilities was established to conduct routine monitoring for people receiving services through DDS who are not members of the Evans class. In addition, Residential Habilitation Services are waiver services provided in licensed homes. These homes are subject to annual licensure reviews by the Department of Health (DOH) Health Regulatory and Licensing Administration (HRLA). The issues identified in these monitoring reports are added into the MCIS Issue Resolution System (IRS) and analyzed with the data for people and providers involved in waiver services. The Quality Improvement Committee (QIC) is a standing committee established by DDS to review the quality of the District's service delivery system and to identify broad areas in need of improvement. The QIC also examines integration, coordination, and capacity aspects of the District's 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 Director of Quality Management Division (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 system's 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 larger stakeholder community and the public are represented by the DDS Management Advisory Committee established by the DDS Director. This committee is comprised of:

1. The Quality Trust for Individuals with Disabilities
2. The Developmental Disabilities (DD) Council
3. DDA Administrators
4. The DC Provider Coalition
5. The Arc of DC

6. Three individual representatives, two from Project ACTION!
7. Three Provider representatives
8. Three parents of individuals receiving waiver services
9. Representative of Georgetown University Center

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 the Continuing Care for Persons with Special Needs Branch 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 DDA's provider certification review process. Upon discovery of problems or issues, DHCF staff persons report the problems or issues to DDS and require a corrective action plan. DHCF monitors DDS' compliance with a corrective action plan through the ongoing implementation of DHCF's Discovery/Remediation Tools.

In addition to the above, DHCF chairs a monthly, joint DHCF/DDS Quality Management Committee (QMC) which was re-established in 2011, and includes key leadership from both agencies. The committee meets monthly and is designed to review performance with the waiver assurances/sub-assurances. Beginning in July 2012, the QMC initiated quarterly meetings that include providers and individuals participating in waiver services. Inclusion of people from these stakeholder groups will facilitate continued communication and ongoing input regarding waiver services.

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**

<b>Responsible Party</b> (check each that applies):	<b>Frequency of Monitoring and Analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Quality Improvement Committee</b>	<input checked="" type="checkbox"/> <b>Annually</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**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 Management Division (QMD) and senior management staff of the Department on Disability Services have primary responsibility for monitoring the effectiveness of system design changes.

DDS uses a Plan-Do-Check-Act (PDCA) Model for implementing, monitoring, and analyzing the effectiveness of system design changes. Specific staff or units are assigned responsibility for monitoring and analyzing the effectiveness of system design changes. Performance measures are discussed at monthly

Performance Management meetings and Quality Improvement Committee (QIC) meetings.

The Quality Management Division reports quarterly to DHCF regarding DDS' discovery and remediation in regards to the waiver assurances and sub-assurances. In addition, the QMD has redesigned the incident management reporting system to analyze incidents and make recommendations for provider and systems improvement. The QMD has also redesigned 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, the Quality Management Division 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. QMD works with internal and external stakeholders and makes recommendations regarding enhancements to the QMS system on an on-going basis.

On an annual basis, considering performance data and input from stakeholders and external monitors, 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. This is then integrated into the One City Performance Management Plan for the DDS.

## Appendix I: Financial Accountability

### I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Although neither the Medicaid State Agency (DHCF), nor the Operating Agency (DDS) require independent audits of waiver provider agencies, both DHCF and DDS have a number of policies and procedures in place to ensure the integrity of payments made for waiver services. In keeping with CMS instructions, technical guide and review criteria, we describe below DHCF's and DDS' post-payment financial audit activities. Prepayment safeguards are discussed later in this appendix.

Foremost, DHCF's Division of Program Integrity (PI) within the Health Care Operations Administration conducts post-payment audits of ID/DD 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 ID/DD waiver. On a monthly basis, PI conducts ongoing audits of DD waiver providers using a statistically significant sample of paid claims. Providers to be audited will be selected based on the amount of paid claims, the number of enrolled providers, and the last time that the provider type or provider was audited for a specific service. In addition to the monthly audits, PI will continue to address fraud and abuse concerns that are brought to the Division's attention on an ad hoc basis.

In addition, as requested by DDS or DHCF, the DC Office of the Inspector General conducts audits if financial practices are questioned. DDS may also request that a provider have an independent audit completed of its program based on concerns identified through the service authorization review process.

Further, all DC Medicaid services, including services provided through this waiver, are subject to the federally required Single Audit, which is performed by an independent auditor procured and managed by the DC Office of the Inspector General.

To supplement the audit process, for the first time, this new waiver will require annual cost reports to be submitted by all providers of Residential Habilitation, Supported Living, Host Home, Day Habilitation, Individualized Day Supports, Employment Readiness, and Supported Employment services. These cost reports will be made available to all auditors as needed.



## Appendix I: Financial Accountability

### Quality Improvement: Financial Accountability

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

**a. Methods for Discovery: Financial Accountability**

*State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (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:**

The percent of cumulative monthly waiver expenditures diverging from projected cumulative monthly expenditures. Numerator: Actual cumulative monthly expenditures for each waiver service. Denominator: Projected cumulative monthly expenditures for each waiver service as specified in Appendix J.

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: State Fiscal intermediary		Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**Number and percent of claims paid with peoples person centered plan authorizations (Claims data, plans of care/authorizations). Number of claims paid in accordance with peoples persons centered plan authorizations/Number of claims reviewed during the quarter.**

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**MMIS**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100%</b>

		<b>Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> <b>Other</b> Specify: State Fiscal intermediary	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: DHCF will review 30 claims
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

**Performance Measure:**

Percent of claims for DD waiver services denied by MMIS, by reason for denial.

Numerator: Number of DD waiver claims denied, by reason of denial.

Denominator: Number of claims submitted for reimbursement of DD 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: State Fiscal Intermediary	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

	<input type="text"/>
--	----------------------

**Performance Measure:****Percent of claims reviewed by Program Integrity audits that fail standards.****Numerator:** Number of audited claims that fail audit standards **Denominator:** Number of claims selected monthly for auditing.**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**MMIS**

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

**Data Aggregation and Analysis:**

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

<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- 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:

**Number and percent 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/Number of claims reviewed during quarter.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**MMIS**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe

<input type="text"/>		Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: DHCf will review 30 claims.
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

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

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 monthly 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 the DHCF Division of Long Term Care's Special Needs Branch under the direction of the Branch Manager. Findings will be shared with the Operating Agency and conclusions and recommendations for remediation will be developed in collaboration with the Operating Agency.

In addition to these systematic strategies for identifying issues within the waiver program, the State Agency and Operating Agency will also document, track, and address individual complaints from beneficiaries, advocates and providers that are received. The quarterly meeting of the Quality Management Committee with stakeholders and the Operating Agency's monthly meetings with providers will serve as key venues for the identification and discovery of issues with the waiver.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. 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 ID/DD 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( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input checked="" type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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).

This information pertains to the Waiver Amendment:

For residence-based services, the Residential Services rate methodology had been revised for the waiver renewal based on cost reporting for the District's ICF/IDD program to DHCF. This amendment modifies the rate methodology for Residential Habilitation and Supported Living to match the overtime and paid time-off corrections implemented in the ICF/IDD rate methodology implemented in October 2014. The HCBS waiver program has not required cost reporting in the past, but is requesting authority to do so in this waiver application to ensure the HCBS rate methodology is sound and does not cause any undo harm to the provider community in providing sufficient services to meet the programmatic, health and welfare needs of HCBS waiver individuals. In addition, the program outlines explicit costs that are NOT covered by the HCBS waiver payment that are attributed to the ICF/IDD program (i.e. Room and Board, therapy services, primary care services, pharmacy services, etc.). DDS' Director has proposed the

rate methodology based on previous experience as a consultant to the District Medicaid agency for the previous ID/DD HCBS waiver application and the updated data available from the Medicaid agency's ICF/IDD cost reports.

The App J is done for the purposes of demonstrating budget neutrality, but the rate changes will not take effect until required in D.C. by the Living Wage Act. Upon approval by CMS of the waiver amendments, D.C. would initiate rate changes for the remainder of Waiver Year 2.

For Day Habilitation, Employment Readiness and Supported Employment Services:

The same general methodology is used with different percentages applied in indirect costs to reflect the different methodology used for an hourly rate for these services to account for supervision, QDDP, and RN oversight time per District regulatory requirements and further adjusted depending on the assumed staff to waiver participant ratio. The hourly rate methodology is based on the DSP wage. It applies the fringe benefit rate and then applies a larger indirect rate (15-20%) to account for supervision, QDDP and RN oversight services, in addition to facility, transportation or other indirect costs associated with day/vocational services. The rate also accounts for an assumption of 85% utilization rate for group services (Day Habilitation, Employment Readiness and Individualized Day Services).

For all Mental Health and Nursing services, the rates are aligned with the District's Medicaid State Plan reimbursement schedule.

This amendment also revises a number of provider payment rates as described further below:

- 1) Provider rates for Residential Habilitation, Supported Living, In-Home Supports, Host Home, Behavioral Support Non-Professional and Respite services to increase to support the increase in the hourly wage rates for the Direct Support Professionals (DSPs) to be in compliance with the D.C. Living Wage Act of 2006 for FY 2014 and FY 2015.
- 2) The Day Habilitation services rate methodology to be changed to include nursing for staff training and oversight of Health Care Management Plans (HCMPs) at a ratio of 1:20, to be paid at the current nursing rate for a Registered Nurse of \$70,000. This change is to improve the health and welfare of Waiver beneficiaries who have complex health support needs and to introduce a small group rate. Other adjustments to the rate methodology was made in response to public comments in areas where provider experience has reflected a need for changes to more accurately reflect reasonable cost allowances..
- 3) Host Home services rate to include a vacancy factor of 93% (1.07), to promote parity with all other residential services which also have a vacancy factor. This was omitted in the waiver renewal.
- 4) Supported Employment (all), Group Supported Employment, and Family Training services wage rates to be increased by the market basket rate for nursing homes for FY 2015 of 1.3%. The rates for these services have not changed in six (6) years.
- 5) Clinical therapy rate research: to address the on-going problem with access to a qualified and adequate provider network in Physical Therapy (PT), Occupational Therapy (OT), Speech, Nutrition and Behavioral Support services, a rate review of other provider networks operating in the District was completed. Two primary competitors for clinicians are working in the schools and early intervention. The Office of the State Superintendent for Education's (OSSE) published rates under 5 DCMR § A-2853 pay \$98.90 per hour for PT, \$100.90 for Speech and \$105.57 for OT. Health Services for Children with Special Needs reports PT and OT at \$125 per hour, and Speech Therapy sessions at \$71.18. Master's prepared counselors through OSSE, the Department of Behavioral Health and the Children and Family Services Administration are paid at \$65.00. Based on the above the following rates are proposed: increase Behavior Paraprofessional from \$60 to \$65 per hour; increase OT, PT and Speech from \$65 to \$100 per hour; and, Nutrition from \$55 to \$60 per hour.
- 6) Art Therapies: Based on the comments from Art and Drama Therapy Institute, Inc. and market research, to increase Art Therapy to \$75 per hour, and to introduce a group rate.
- 7) Fitness: Based on current market conditions, to reduce the rate from \$75 to \$50 per hour, and to introduce a group rate.
- 8) Individualized Day Supports rate to be reduced from \$24.44 per hour to \$21.79 per hour, based on market research and to promote parity with other individualized supports.
- 9) Adjustments were made to the rate methodology for Employment Readiness in areas where provider experience has reflected a need for changes to more accurately reflect reasonable cost allowances.
- 10) Upon approval of the IDD HCBS waiver by CMS, DHCF and DDS intend to increase all rates in subsequent years based on requirements of the D.C. Living Wage Act of 2006 and the market basket indicators index for nursing homes to keep pace with inflation using appropriate Medicaid long-term care services.

With respect to public comment:

The foundation of Residential Services has been vetted via the ICF/IDD rate methodology. Costs reporting have been debated with the provider community during the ICF/IDD rate methodology negotiations with the District provider community from December 2011 through February 2012. The day services suite has not been altered dramatically

with the exception of an increase in assumptions for DSP wages and a decrease in fringe benefits paid, indirect costs and general and administrative costs, which are based on costs reports from the provider community related to ICF/IDD expenditures. Residential and Day service rates were presented to the provider community in advance of this submission. Adjustments were made in Day service rates based on documentation supplied by the Day service provider coalition, re-presented and generally accepted.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All provider billings flow directly from providers to the State's claims payment system.

The District Medicaid Management Information System (MMIS) 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 Xerox. Xerox 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. Xerox 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

## 1.2. RULES, BILLING AND CLAIMS (6 of 6)

- d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Validation of provider billing occurs in several ways. With respect to assuring that all claims for payments are made only when the individual is eligible for Medicaid waiver payment on the date of service, all claims for DD waiver services must pass a series of payment edits. These edits allow claims to be paid only: 1) to providers who are enrolled in the waiver program and have a waiver provider number, and 2) for individuals who are enrolled in the waiver and have a waiver program enrollment code on the date of service. Claims can only be paid by Medicaid if they are for services delivered to a waiver individual by a provider enrolled in the waiver on the date of service. In addition, a series of service-specific edits are placed in MMIS to prevent payment for services in excess of approved waiver limits.

With respect to ensuring that the service being billed is actually included in the individual's 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 individual's 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 individual's 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 provider's 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 DHCF's contractor into MMIS.

Verification that the services billed for are actually provided is undertaken retrospectively. DHCF's Division of Program Integrity (PI) within the Health Care Operations Administration conducts post-payment audits of ID/DD 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 ID/DD 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 Division's 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.

## 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.** *Select one:*

- ☒ **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.**

## Appendix I: Financial Accountability

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

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

- ☒ **Appropriation of State Tax Revenues to the State Medicaid agency**
- ☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- ☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:



## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

- b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

☒ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

☐ **Applicable**

*Check each that applies:*

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

## Appendix I: Financial Accountability

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

- c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

☒ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

☐ **The following source(s) are used**

*Check each that applies:*

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings. *Select one:***

- ☐ No services under this waiver are furnished in residential settings other than the private residence of the individual.
- ☒ As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The HCBS Waiver rate methodology for residential services explicitly excludes payments for Room and Board, with the singular exception of Daily Respite. DDS collects the waiver individuals SSI/SSDI benefit for those who receive Residential Habilitation and/or Supported Living and in turn provides a \$100.00 per month of personal needs allowance and all room and board expenses incurred on behalf of the waiver individual for these specific services. For Host Home services, the HCBS waiver individual's maximum SSI payment is made available to the Host Home provider which is less than the personal needs allowance of \$100.00 per month, to account for the HCBS waiver individual's room and board costs.

For Daily Respite, the waiver payment includes as allowable, a payment for daily room and board equivalent to \$20.00 a day.

## 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:

The participant will supply the lease or ownership papers for the home verifying that the participant is the lessee or the owner of the house, and an agreement between the participant and the live-in caregiver outlining the expectation and elements of waiver services to be provided. The rent will be based on the cost of the residence and apportioned to the living space for the caregiver. In most cases this will be an equal split among the residents of the home. Food will be based on USDA rates for annual food costs for District residents. The sponsoring provider agency will submit claims on behalf of the participant to DDS for payment, and transfer the funds to the participant for the specified household 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	136252.37	26168.63	162421.00	161274.58	38795.76	200070.34	37649.34
2	132080.13	26875.18	158955.31	169580.36	39843.24	209423.60	50468.29
3	133624.56	27600.81	161225.37	177886.14	40919.01	218805.15	57579.78
4	144251.47	28346.03	172597.50	186191.92	42023.83	228215.75	55618.25
5	148754.16	29111.38	177865.54	194497.70	43158.47	237656.17	59790.63

## 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	1592	1592

Year 2	1642	1642
Year 3	1692	1692
Year 4	1692	1692
Year 5	1692	1692

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay (ALOS) was used as a limiting factor for participant utilization in per diem waiver services. As an example, if participants using the supported living service projected to use 350 days of this service on average, but the ALOS was 345 days, the projection was capped at 345 days per participant. Since historical data was used to generate the projections, this was deemed the most relevant method to incorporate ALOS into the estimates.

## 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 for these estimates is as follows:  
  
To generate estimates for Factor D, we utilized historical data from waiver years 1-4 to project the number of users and average units per user for all waiver services. In general, the number of users were calculated by trending past enrollment in each service in relation to total unduplicated waiver enrollment. Average units per user were calculated by trending historical utilization over time. Rates were update where applicable. The product of the users, average units per user, and the rate yielded the cost projection for each waiver service.
  - 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:  
  
To estimate Factor D', 2.7% growth rate was applied to most recent waiver year (waiver year 4) actual for D'. This percentage was applied to each successive year of the new waiver. 2.7% is the market basket rate for nursing homes.
  - iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:  
  
Factor G was projected by trending historical actuals over time. The agency has Factor G actuals for waiver years 1-4 of the current waiver.
  - 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:  
  
To estimate Factor D', 2.7% growth rate was applied to most recent waiver year (waiver year 4) actual for D'. This percentage was applied to each successive year of the new waiver. 2.7% is the market basket rate for nursing homes.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services
Day Habilitation
Employment Readiness
In-Home Supports
Residential Habilitation
Respite
Supported Employment
Personal Care Services
Skilled Nursing
Behavioral Supports
Companion Services
Creative Art Therapies
Dental
Environmental Accessibilities Adaptations
Family Training
Host Home
Individualized Day Supports
Occupational Therapy
One-Time Transitional Services
Personal Emergency Response System (PERS)
Physical Therapy
Small Group Supported Employment
Speech, Hearing and Language Services
Supported Living with Transportation
Supported Living
Vehicle Modifications
Wellness Services

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 9)

#### d. Estimate of Factor D.

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:							15351427.14
Day Habilitation Individual	<input type="checkbox"/>	15 minutes	75	3320.00	6.01	1496490.00	

Day Habilitation Group	<input type="checkbox"/>	15 minutes	594	3881.00	6.01	13854937.14	
Day Habilitation Sm Facility	<input type="checkbox"/>	15 minutes	0	0.00	0.01	0.00	
<b>Employment Readiness Total:</b>							4196322.90
Employment Readiness	<input type="checkbox"/>	15 minutes	385	3187.00	3.42	4196322.90	
<b>In-Home Supports Total:</b>							12480724.08
In-Home Supports	<input type="checkbox"/>	15 minutes	424	5049.00	5.83	12480724.08	
<b>Residential Habilitation Total:</b>							27109879.20
Residential Habilitation	<input type="checkbox"/>	1 day	207	277.00	472.80	27109879.20	
<b>Respite Total:</b>							926035.35
Hourly	<input type="checkbox"/>	15 minutes	85	1109.00	5.19	489235.35	
Daily	<input type="checkbox"/>	1 day	78	14.00	400.00	436800.00	
<b>Supported Employment Total:</b>							1604016.96
Supported Employment	<input type="checkbox"/>	15 minutes	302	477.00	9.44	1359869.76	
Long-Term FU	<input type="checkbox"/>	15 minutes	10	4224.00	5.78	244147.20	
<b>Personal Care Services Total:</b>							70584.84
Personal Care Services	<input type="checkbox"/>	15 minutes	4	4056.60	4.35	70584.84	
<b>Skilled Nursing Total:</b>							140880.00
Visit/RN	<input type="checkbox"/>	visit	14	32.00	65.00	29120.00	
Extended/RN	<input type="checkbox"/>	15 minutes	3	3525.00	8.00	84600.00	
Extended/LPN/LVN	<input type="checkbox"/>	15 minutes	2	2716.00	5.00	27160.00	
<b>Behavioral Supports Total:</b>							29708825.87
Diagnostic Assessment	<input type="checkbox"/>	flat rate	175	1.00	243.12	42546.00	
Behavioral Supports	<input type="checkbox"/>	15 minutes	751	2449.00	16.13	29666279.87	
<b>Companion Services Total:</b>							0.00
Companion Services	<input type="checkbox"/>	0	0	0.00	0.01	0.00	
<b>Creative Art Therapies Total:</b>							25875.00
Creative Art Therapies	<input type="checkbox"/>	45 minutes	69	5.00	75.00	25875.00	
Arts Therapies (Art Therapy) group	<input type="checkbox"/>	45 minutes	0	0.00	0.01	0.00	
Arts Therapies (Music Therapy) group	<input type="checkbox"/>	45 minutes	0	0.00	0.01	0.00	
<b>Dental Total:</b>							44897.76
Dental	<input type="checkbox"/>	visit	547	1.00	82.08	44897.76	

<b>Environmental Accessibilities Adaptations Total:</b>							<b>20000.00</b>
Environmental Accessibilities Adaptations	<input type="checkbox"/>	annual	2	1.00	10000.00	20000.00	
<b>Family Training Total:</b>							<b>97675.20</b>
F Caregiver Training,	<input type="checkbox"/>	15 minutes	49	119.00	15.20	88631.20	
N Caregiver Training,	<input type="checkbox"/>	15 minutes	5	119.00	15.20	9044.00	
<b>Host Home Total:</b>							<b>7402171.00</b>
Host Home	<input type="checkbox"/>	1 day	94	298.00	264.25	7402171.00	
<b>Individualized Day Supports Total:</b>							<b>0.00</b>
Individualized Day Individual	<input type="checkbox"/>	15 minutes	0	0.00	9.23	0.00	
Individualized Day Group	<input type="checkbox"/>	15 minutes	0	0.00	5.22	0.00	
<b>Occupational Therapy Total:</b>							<b>20350.00</b>
Occupational Therapy	<input type="checkbox"/>	15 minutes	55	14.80	25.00	20350.00	
<b>One-Time Transitional Services Total:</b>							<b>10000.00</b>
One-Time Transitional Services	<input type="checkbox"/>	1 unit	2	1.00	5000.00	10000.00	
<b>Personal Emergency Response System (PERS) Total:</b>							<b>3300.00</b>
Installation and Testing	<input type="checkbox"/>	flat rate	5	6.00	50.00	1500.00	
Monthly Service	<input type="checkbox"/>	flat rate	5	12.00	30.00	1800.00	
<b>Physical Therapy Total:</b>							<b>65490.00</b>
Physical Therapy	<input type="checkbox"/>	15 minutes	111	23.60	25.00	65490.00	
<b>Small Group Supported Employment Total:</b>							<b>352788.48</b>
Small Group Supported Employment	<input type="checkbox"/>	15 minutes	16	4224.00	5.22	352788.48	
<b>Speech, Hearing and Language Services Total:</b>							<b>611625.00</b>
Speech, Hearing and Language Services	<input type="checkbox"/>	15 minutes	210	116.50	25.00	611625.00	
<b>Supported Living with Transportation Total:</b>							<b>56039837.48</b>
Supported Living 1 Res (Periodic) w/ Transportation	<input type="checkbox"/>	15 minutes	99	4992.00	6.56	3242004.48	
Supported Living 3 Res (Basic 1) w/ Transportation	<input type="checkbox"/>	1 day	5	273.00	296.00	404040.00	
Supported Living 3 Res (Basic 2) w/ Transportation	<input type="checkbox"/>	1 day	28	298.00	304.00	2536576.00	
Supported Living 3							



Res (Moderate 1) w/ Transportation	<input type="checkbox"/>	1 day	2	201.00	357.00	143514.00	
Supported Living 3 Res (Moderate 2) w/ Transportation	<input type="checkbox"/>	1 day	8	230.00	364.00	669760.00	
Supported Living 3 Res (Intensive 1) w/ Transportation	<input type="checkbox"/>	1 day	37	284.00	424.00	4455392.00	
Supported Living 3 Res (Intensive 2) w/ Transportation	<input type="checkbox"/>	1 day	62	268.00	495.00	8224920.00	
Supported Living 3 Intensive w/ LPN w/ Transportation	<input type="checkbox"/>	1 day	4	306.00	657.00	804168.00	
Supported Living 2 Res (Basic 1) w/ Transportation	<input type="checkbox"/>	1 day	13	242.00	363.00	1141998.00	
Supported Living 2 Res (Basic 2) w/ Transportation	<input type="checkbox"/>	1 day	130	306.00	374.00	14877720.00	
Supported Living 2 Res (Moderate 1) w/ Transportation	<input type="checkbox"/>	1 day	2	365.00	436.00	318280.00	
Supported Living 2 Res (Moderate 2) w/ Transportation	<input type="checkbox"/>	1 day	17	319.00	531.00	2879613.00	
Supported Living 2 Res (Intensive 1) w/ Transportation	<input type="checkbox"/>	1 day	64	235.00	594.00	8933760.00	
Supported Living 1 Res (Asleep Overnt) w/ Transportation	<input type="checkbox"/>	1 day	4	147.00	645.00	379260.00	
Supported Living 1 Res (Awake Overnt) w/ Transportation	<input type="checkbox"/>	1 day	48	211.00	694.00	7028832.00	
<b>Supported Living Total:</b>							<b>60064946.44</b>
Supported Living 1 Res (Periodic)	<input type="checkbox"/>	15 minutes	318	4992.00	5.99	9508861.44	
Supported Living 3 Res (Basic 1)	<input type="checkbox"/>	1 day	5	273.00	275.00	375375.00	
Supported Living 3 Res (Basic 2)	<input type="checkbox"/>	1 day	28	298.00	283.00	2361352.00	
Supported Living 3 Res (Moderate 1)	<input type="checkbox"/>	1 day	2	201.00	337.00	135474.00	
Supported Living 3 Res (Moderate 2)	<input type="checkbox"/>	1 day	8	230.00	343.00	631120.00	
Supported Living 3 Res (Intensive 1)	<input type="checkbox"/>	1 day	37	284.00	403.00	4234724.00	
Supported Living 3 Res (Intensive 2)	<input type="checkbox"/>	1 day	62	268.00	475.00	7892600.00	
Supported Living 3 Intensive w/ LPN	<input type="checkbox"/>	1 day	4	306.00	657.00	804168.00	
Supported Living 2 Res (Basic 1)	<input type="checkbox"/>	1 day	13	242.00	343.00	1079078.00	
Supported Living 2 Res (Basic 2)	<input type="checkbox"/>	1 day	130	306.00	356.00	14161680.00	
Supported Living 2 Res (Moderate 1)	<input type="checkbox"/>	1 day	2	365.00	416.00	303680.00	
Supported Living 2 Res (Moderate 2)	<input type="checkbox"/>	1 day	17	319.00	510.00	2765730.00	
Supported Living 2 Res (Intensive 1)	<input type="checkbox"/>	1 day	64	235.00	573.00	8617920.00	
Supported Living 1						366912.00	

Res (Asleep Overnt)	<input type="checkbox"/>	1 day	4	147.00	624.00		
Supported Living 1 Res (Awake Overnt)	<input type="checkbox"/>	1 day	48	211.00	674.00	6826272.00	
<b>Vehicle Modifications Total:</b>							50000.00
Vehicle Modifications	<input type="checkbox"/>	modification	5	1.00	10000.00	50000.00	
<b>Wellness Services Total:</b>							516122.06
Nutritional Counseling	<input type="checkbox"/>	15 minutes	881	25.50	15.00	336982.50	
Bereavement Counseling	<input type="checkbox"/>	15 minutes	49	119.00	0.01	58.31	
Massage Therapy	<input type="checkbox"/>	15 minutes	0	0.00	15.00	0.00	
Sexual Education	<input type="checkbox"/>	15 minutes	25	47.00	18.75	22031.25	
Fitness Trainer Individual	<input type="checkbox"/>	15 minutes	80	104.70	18.75	157050.00	
Fitness Trainer Group	<input type="checkbox"/>	15 minutes	0	0.00	7.50	0.00	
<b>GRAND TOTAL:</b>						216913774.76	
Total: Services included in capitation:							
Total: Services not included in capitation:						216913774.76	
<b>Total Estimated Unduplicated Participants:</b>						1592	
<b>Factor D (Divide total by number of participants):</b>						136252.37	
Services included in capitation:							
Services not included in capitation:						136252.37	
<b>Average Length of Stay on the Waiver:</b>						345	

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Habilitation Total:</b>							15351427.14
Day Habilitation Individual	<input type="checkbox"/>	15 minutes	75	3320.00	6.01	1496490.00	
Day Habilitation Group	<input type="checkbox"/>	15 minutes	594	3881.00	6.01	13854937.14	
Day Habilitation Sm Facility	<input type="checkbox"/>	15 minutes	0	0.00	0.01	0.00	
<b>Employment Readiness Total:</b>							4196322.90
Employment Readiness	<input type="checkbox"/>	15 minutes	385	3187.00	3.42	4196322.90	

<b>In-Home Supports Total:</b>							12480724.08
In-Home Supports	<input type="checkbox"/>	15 minutes	424	5049.00	5.83	12480724.08	
<b>Residential Habilitation Total:</b>							27109879.20
Residential Habilitation	<input type="checkbox"/>	1 day	207	277.00	472.80	27109879.20	
<b>Respite Total:</b>							926035.35
Hourly	<input type="checkbox"/>	15 minutes	85	1109.00	5.19	489235.35	
Daily	<input type="checkbox"/>	1 day	78	14.00	400.00	436800.00	
<b>Supported Employment Total:</b>							1604016.96
Supported Employment	<input type="checkbox"/>	15 minutes	302	477.00	9.44	1359869.76	
Long-Term FU	<input type="checkbox"/>	15 minutes	10	4224.00	5.78	244147.20	
<b>Personal Care Services Total:</b>							70584.84
Personal Care Services	<input type="checkbox"/>	15 minutes	4	4056.60	4.35	70584.84	
<b>Skilled Nursing Total:</b>							140880.00
Visit/RN	<input type="checkbox"/>	Visit	14	32.00	65.00	29120.00	
Extended/RN	<input type="checkbox"/>	15 minutes	3	3525.00	8.00	84600.00	
Extended/LPN/LVN	<input type="checkbox"/>	15 minutes	2	2716.00	5.00	27160.00	
<b>Behavioral Supports Total:</b>							29708825.87
Diagnostic Assessment	<input type="checkbox"/>	flat rate	175	1.00	243.12	42546.00	
Behavioral Supports	<input type="checkbox"/>	15 minutes	751	2449.00	16.13	29666279.87	
<b>Companion Services Total:</b>							0.00
Companion Services	<input type="checkbox"/>	15 minutes	0	0.00	0.01	0.00	
<b>Creative Art Therapies Total:</b>							25875.00
Creative Art Therapies	<input type="checkbox"/>	45 minutes	69	5.00	75.00	25875.00	
Arts Therapies (Art Therapy) group	<input type="checkbox"/>	45 minutes	0	0.00	21.88	0.00	
Arts Therapies (Music Therapy) group	<input type="checkbox"/>	45 minutes	0	0.00	21.88	0.00	
<b>Dental Total:</b>							44897.76
Dental	<input type="checkbox"/>	visit	547	1.00	82.08	44897.76	
<b>Environmental Accessibilities Adaptations Total:</b>							20000.00
Environmental Accessibilities Adaptations	<input type="checkbox"/>	annual	2	1.00	10000.00	20000.00	
<b>Family Training Total:</b>							97675.20

F Caregiver Training,	<input type="checkbox"/>	15 minutes	49	119.00	15.20	88631.20	
N Caregiver Training,	<input type="checkbox"/>	15 minutes	5	119.00	15.20	9044.00	
<b>Host Home Total:</b>							<b>7402171.00</b>
Host Home	<input type="checkbox"/>	1 day	94	298.00	264.25	7402171.00	
<b>Individualized Day Supports Total:</b>							<b>0.00</b>
Individualized Day Individual	<input type="checkbox"/>	15 minutes	0	0.00	9.23	0.00	
Individualized Day Group	<input type="checkbox"/>	15 minutes	0	0.00	5.22	0.00	
<b>Occupational Therapy Total:</b>							<b>20350.00</b>
Occupational Therapy	<input type="checkbox"/>	15 minutes	55	14.80	25.00	20350.00	
<b>One-Time Transitional Services Total:</b>							<b>10000.00</b>
One-Time Transitional Services	<input type="checkbox"/>	1 unit	2	1.00	5000.00	10000.00	
<b>Personal Emergency Response System (PERS) Total:</b>							<b>3300.00</b>
Installation and Testing	<input type="checkbox"/>	flat rate	5	6.00	50.00	1500.00	
Monthly Service	<input type="checkbox"/>	flat rate	5	12.00	30.00	1800.00	
<b>Physical Therapy Total:</b>							<b>65490.00</b>
Physical Therapy	<input type="checkbox"/>	15 minutes	111	23.60	25.00	65490.00	
<b>Small Group Supported Employment Total:</b>							<b>352788.48</b>
Small Group Supported Employment	<input type="checkbox"/>	15 minutes	16	4224.00	5.22	352788.48	
<b>Speech, Hearing and Language Services Total:</b>							<b>611625.00</b>
Speech, Hearing and Language Services	<input type="checkbox"/>	15 minutes	210	116.50	25.00	611625.00	
<b>Supported Living with Transportation Total:</b>							<b>56039837.48</b>
Supported Living 1 Res (Periodic) w/ Transportation	<input type="checkbox"/>	15 minutes	99	4992.00	6.56	3242004.48	
Supported Living 3 Res (Basic 1) w/ Transportation	<input type="checkbox"/>	1 day	5	273.00	296.00	404040.00	
Supported Living 3 Res (Basic 2) w/ Transportation	<input type="checkbox"/>	1 day	28	298.00	304.00	2536576.00	
Supported Living 3 Res (Moderate 1) w/ Transportation	<input type="checkbox"/>	1 day	2	201.00	357.00	143514.00	
Supported Living 3 Res (Moderate 2) w/ Transportation	<input type="checkbox"/>	1 day	8	230.00	364.00	669760.00	
Supported Living 3 Res (Intensive 1) w/ Transportation	<input type="checkbox"/>	1 day	37	284.00	424.00	4455392.00	

Supported Living 3 Res (Intensive 2) w/ Transportation	<input type="checkbox"/>	1 day	62	268.00	495.00	8224920.00	
Supported Living 3 Intensive w/ LPN w/ Transportation	<input type="checkbox"/>	1 day	4	306.00	657.00	804168.00	
Supported Living 2 Res (Basic 1) w/ Transportation	<input type="checkbox"/>	1 day	13	242.00	363.00	1141998.00	
Supported Living 2 Res (Basic 2) w/ Transportation	<input type="checkbox"/>	1 day	130	306.00	374.00	14877720.00	
Supported Living 2 Res (Moderate 1) w/ Transportation	<input type="checkbox"/>	1 day	2	365.00	436.00	318280.00	
Supported Living 2 Res (Moderate 2) w/ Transportation	<input type="checkbox"/>	1 day	17	319.00	531.00	2879613.00	
Supported Living 2 Res (Intensive 1) w/ Transportation	<input type="checkbox"/>	1 day	64	235.00	594.00	8933760.00	
Supported Living 1 Res (Asleep Overnt) w/ Transportation	<input type="checkbox"/>	1 day	4	147.00	645.00	379260.00	
Supported Living 1 Res (Awake Overnt) w/ Transportation	<input type="checkbox"/>	1 day	48	211.00	694.00	7028832.00	
<b>Supported Living Total:</b>							60064946.44
Supported Living 1 Res (Periodic)	<input type="checkbox"/>	15 minutes	318	4992.00	5.99	9508861.44	
Supported Living 3 Res (Basic 1)	<input type="checkbox"/>	1 day	5	273.00	275.00	375375.00	
Supported Living 3 Res (Basic 2)	<input type="checkbox"/>	1 day	28	298.00	283.00	2361352.00	
Supported Living 3 Res (Moderate 1)	<input type="checkbox"/>	1 day	2	201.00	337.00	135474.00	
Supported Living 3 Res (Moderate 2)	<input type="checkbox"/>	1 day	8	230.00	343.00	631120.00	
Supported Living 3 Res (Intensive 1)	<input type="checkbox"/>	1 day	37	284.00	403.00	4234724.00	
Supported Living 3 Res (Intensive 2)	<input type="checkbox"/>	1 day	62	268.00	475.00	7892600.00	
Supported Living 3 Intensive w/ LPN	<input type="checkbox"/>	1 day	4	306.00	657.00	804168.00	
Supported Living 2 Res (Basic 1)	<input type="checkbox"/>	1 day	13	242.00	343.00	1079078.00	
Supported Living 2 Res (Basic 2)	<input type="checkbox"/>	1 day	130	306.00	356.00	14161680.00	
Supported Living 2 Res (Moderate 1)	<input type="checkbox"/>	1 day	2	365.00	416.00	303680.00	
Supported Living 2 Res (Moderate 2)	<input type="checkbox"/>	1 day	17	319.00	510.00	2765730.00	
Supported Living 2 Res (Intensive 1)	<input type="checkbox"/>	1 day	64	235.00	573.00	8617920.00	
Supported Living 1 Res (Asleep Overnt)	<input type="checkbox"/>	1 day	4	147.00	624.00	366912.00	
Supported Living 1 Res (Awake Overnt)	<input type="checkbox"/>	1 day	48	211.00	674.00	6826272.00	
<b>Vehicle Modifications Total:</b>							50000.00
Vehicle Modifications	<input type="checkbox"/>	modification	5	1.00	10000.00	50000.00	
<b>Wellness Services</b>							

<b>Total:</b>							477915.55
Nutritional Counseling	<input type="checkbox"/>	15 minutes	881	25.50	15.00	336982.50	
Bereavement Counseling	<input type="checkbox"/>	15 minutes	10	18.00	0.01	1.80	
Massage Therapy	<input type="checkbox"/>	15 minutes	0	0.00	15.00	0.00	
Sexual Education	<input type="checkbox"/>	15 minutes	25	47.00	18.75	22031.25	
Fitness Trainer Individual	<input type="checkbox"/>	15 minutes	82	116.00	12.50	118900.00	
Fitness Trainer Group	<input type="checkbox"/>	15 minutes	0	0.00	7.50	0.00	
<b>GRAND TOTAL:</b>							216875568.25
Total: Services included in capitation:							216875568.25
Total: Services not included in capitation:							1642
<b>Total Estimated Unduplicated Participants:</b>							132080.13
<b>Factor D (Divide total by number of participants):</b>							132080.13
Services included in capitation:							132080.13
Services not included in capitation:							
<b>Average Length of Stay on the Waiver:</b>							351

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

#### d. Estimate of Factor D.

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 3

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Habilitation Total:</b>							19947001.60
Day Habilitation Individual	<input type="checkbox"/>	15 minutes	80	3350.00	11.82	3167760.00	
Day Habilitation Group	<input type="checkbox"/>	15 minutes	512	4092.00	6.65	13932441.60	
Day Habilitation Sm Facility	<input type="checkbox"/>	15 minutes	100	2200.00	12.94	2846800.00	
<b>Employment Readiness Total:</b>							4455473.60
Employment Readiness	<input type="checkbox"/>	15 minutes	395	3232.00	3.49	4455473.60	
<b>In-Home Supports Total:</b>							13401459.72
In-Home Supports	<input type="checkbox"/>	15 minutes	438	5049.00	6.06	13401459.72	
<b>Residential Habilitation Total:</b>							26644262.40
Residential Habilitation	<input type="checkbox"/>	1 day	192	282.00	492.10	26644262.40	

<b>Respite Total:</b>							3419400.00
Hourly	<input type="checkbox"/>	15 minutes	200	1700.00	5.29	1798600.00	
Daily	<input type="checkbox"/>	1 day	200	20.00	405.20	1620800.00	
<b>Supported Employment Total:</b>							2100445.44
Supported Employment	<input type="checkbox"/>	15 minutes	304	624.00	9.63	1826772.48	
Long-Term FU	<input type="checkbox"/>	15 minutes	11	4224.00	5.89	273672.96	
<b>Personal Care Services Total:</b>							94558.35
Personal Care Services	<input type="checkbox"/>	15 minutes	5	4269.00	4.43	94558.35	
<b>Skilled Nursing Total:</b>							147835.00
Visit/RN	<input type="checkbox"/>	Visit	15	37.00	65.00	36075.00	
Extended/RN	<input type="checkbox"/>	15 minutes	3	3525.00	8.00	84600.00	
Extended/LPN/LVN	<input type="checkbox"/>	15 minutes	2	2716.00	5.00	27160.00	
<b>Behavioral Supports Total:</b>							32647457.55
Diagnostic Assessment	<input type="checkbox"/>	flat rate	165	1.00	246.28	40636.20	
Behavioral Supports	<input type="checkbox"/>	15 minutes	783	2547.00	16.35	32606821.35	
<b>Companion Services Total:</b>							410904.00
Companion Services	<input type="checkbox"/>	15 minutes	25	3744.00	4.39	410904.00	
<b>Creative Art Therapies Total:</b>							192225.00
Creative Art Therapies	<input type="checkbox"/>	45 minutes	75	5.00	75.00	28125.00	
Arts Therapies (Art Therapy) group	<input type="checkbox"/>	45 minutes	50	60.00	21.88	65640.00	
Arts Therapies (Music Therapy) group	<input type="checkbox"/>	45 minutes	75	60.00	21.88	98460.00	
<b>Dental Total:</b>							46293.12
Dental	<input type="checkbox"/>	visit	564	1.00	82.08	46293.12	
<b>Environmental Accessibilities Adaptations Total:</b>							40000.00
Environmental Accessibilities Adaptations	<input type="checkbox"/>	annual	4	1.00	10000.00	40000.00	
<b>Family Training Total:</b>							110656.00
Caregiver Training, F	<input type="checkbox"/>	15 minutes	51	130.00	15.20	100776.00	
Caregiver Training, N	<input type="checkbox"/>	15 minutes	5	130.00	15.20	9880.00	
<b>Host Home Total:</b>							7316672.00
Host Home	<input type="checkbox"/>	1 day	88	304.00	273.50	7316672.00	

<b>Individualized Day Supports Total:</b>							4361560.00
Individualized Day Individual	<input type="checkbox"/>	15 minutes	250	840.00	9.42	1978200.00	
Individualized Day Group	<input type="checkbox"/>	15 minutes	400	1120.00	5.32	2383360.00	
<b>Occupational Therapy Total:</b>							18525.00
Occupational Therapy	<input type="checkbox"/>	15 minutes	57	13.00	25.00	18525.00	
<b>One-Time Transitional Services Total:</b>							10000.00
One-Time Transitional Services	<input type="checkbox"/>	1 unit	2	1.00	5000.00	10000.00	
<b>Personal Emergency Response System (PERS) Total:</b>							3323.40
Installation and Testing	<input type="checkbox"/>	flat rate	5	6.00	50.00	1500.00	
Monthly Service	<input type="checkbox"/>	flat rate	5	12.00	30.39	1823.40	
<b>Physical Therapy Total:</b>							68400.00
Physical Therapy	<input type="checkbox"/>	15 minutes	114	24.00	25.00	68400.00	
<b>Small Group Supported Employment Total:</b>							359546.88
Small Group Supported Employment	<input type="checkbox"/>	15 minutes	16	4224.00	5.32	359546.88	
<b>Speech, Hearing and Language Services Total:</b>							637200.00
Speech, Hearing and Language Services	<input type="checkbox"/>	15 minutes	216	118.00	25.00	637200.00	
<b>Supported Living with Transportation Total:</b>							55287886.91
Supported Living 1 Res (Periodic) w/ Transportation	<input type="checkbox"/>	15 minutes	105	4992.00	6.70	3511872.00	
Supported Living 3 Res (Basic 1) w/ Transportation	<input type="checkbox"/>	1 day	5	288.00	304.00	437760.00	
Supported Living 3 Res (Basic 2) w/ Transportation	<input type="checkbox"/>	1 day	28	318.00	312.00	2778048.00	
Supported Living 3 Res (Moderate 1) w/ Transportation	<input type="checkbox"/>	1 day	2	220.00	368.00	161920.00	
Supported Living 3 Res (Moderate 2) w/ Transportation	<input type="checkbox"/>	1 day	8	250.00	375.00	750000.00	
Supported Living 3 Res (Intensive 1) w/ Transportation	<input type="checkbox"/>	1 day	38	291.00	436.00	4821288.00	
Supported Living 3 Res (Intensive 2) w/ Transportation	<input type="checkbox"/>	1 day	24	288.00	509.00	3518208.00	
Supported Living 3 Intensive w/ LPN w/ Transportation	<input type="checkbox"/>	1 day	5	312.00	610.00	951600.00	
Supported Living 2 Res (Basic 1) w/ Transportation	<input type="checkbox"/>	1 day	12	240.00	353.00	1016640.00	



Supported Living 2 Res (Basic 2) w/ Transportation	<input type="checkbox"/>	1 day	139	319.00	383.51	17005216.91	
Supported Living 2 Res (Moderate 1) w/ Transportation	<input type="checkbox"/>	1 day	2	365.00	449.00	327770.00	
Supported Living 2 Res (Moderate 2) w/ Transportation	<input type="checkbox"/>	1 day	16	338.00	545.00	2947360.00	
Supported Living 2 Res (Intensive 1) w/ Transportation	<input type="checkbox"/>	1 day	68	241.00	610.00	9996680.00	
Supported Living 1 Res (Asleep Overnt) w/ Transportation	<input type="checkbox"/>	1 day	4	147.00	663.00	389844.00	
Supported Living 1 Res (Awake Overnt) w/ Transportation	<input type="checkbox"/>	1 day	45	208.00	713.00	6673680.00	
<b>Supported Living Total:</b>							53716402.00
Supported Living 1 Res (Periodic)	<input type="checkbox"/>	15 minutes	105	4992.00	6.11	3202617.60	
Supported Living 3 Res (Basic 1)	<input type="checkbox"/>	1 day	5	288.00	284.00	408960.00	
Supported Living 3 Res (Basic 2)	<input type="checkbox"/>	1 day	28	318.00	292.00	2599968.00	
Supported Living 3 Res (Moderate 1)	<input type="checkbox"/>	1 day	2	220.00	348.00	153120.00	
Supported Living 3 Res (Moderate 2)	<input type="checkbox"/>	1 day	8	250.00	354.00	708000.00	
Supported Living 3 Res (Intensive 1)	<input type="checkbox"/>	1 day	38	291.00	416.00	4600128.00	
Supported Living 3 Res (Intensive 2)	<input type="checkbox"/>	1 day	24	288.00	488.00	3373056.00	
Supported Living 3 Intensive w/ LPN	<input type="checkbox"/>	1 day	5	312.00	610.00	951600.00	
Supported Living 2 Res (Basic 1)	<input type="checkbox"/>	1 day	12	240.00	353.00	1016640.00	
Supported Living 2 Res (Basic 2)	<input type="checkbox"/>	1 day	139	319.00	364.00	16140124.00	
Supported Living 2 Res (Moderate 1)	<input type="checkbox"/>	1 day	2	365.00	429.00	313170.00	
Supported Living 2 Res (Moderate 2)	<input type="checkbox"/>	1 day	16	338.00	525.00	2839200.00	
Supported Living 2 Res (Intensive 1)	<input type="checkbox"/>	1 day	68	241.00	642.00	10521096.00	
Supported Living 1 Res (Asleep Overnt)	<input type="checkbox"/>	1 day	4	147.00	693.00	407484.00	
Supported Living 1 Res (Awake Overnt)	<input type="checkbox"/>	1 day	45	208.00	692.44	6481238.40	
<b>Vehicle Modifications Total:</b>							50000.00
Vehicle Modifications	<input type="checkbox"/>	modification	5	1.00	10000.00	50000.00	
<b>Wellness Services Total:</b>							605272.72
Nutritional Counseling	<input type="checkbox"/>	15 minutes	913	25.00	15.20	346940.00	
Bereavement Counseling	<input type="checkbox"/>	15 minutes	10	18.00	15.00	2700.00	
Massage Therapy	<input type="checkbox"/>	15 minutes	0	0.00	15.20	0.00	

Sexual Education	<input type="checkbox"/>	15 minutes	28	51.00	18.99	27117.72	
Fitness Trainer Individual	<input type="checkbox"/>	15 minutes	85	126.00	12.50	133875.00	
Fitness Trainer Group	<input type="checkbox"/>	15 minutes	200	70.00	6.76	94640.00	
<b>GRAND TOTAL:</b>						226092760.69	
Total: Services included in capitation:							
Total: Services not included in capitation:						226092760.69	
Total Estimated Unduplicated Participants:						1692	
Factor D (Divide total by number of participants):						133624.56	
Services included in capitation:							
Services not included in capitation:						133624.56	
Average Length of Stay on the Waiver:						357	

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

#### d. Estimate of Factor D.

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 4

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Habilitation Total:</b>							21167709.60
Day Habilitation Individual	<input type="checkbox"/>	15 minutes	80	3381.00	12.09	3270103.20	
Day Habilitation Group	<input type="checkbox"/>	15 minutes	512	4304.00	6.80	14984806.40	
Day Habilitation Sm Facility	<input type="checkbox"/>	15 minutes	100	2200.00	13.24	2912800.00	
<b>Employment Readiness Total:</b>							4622471.70
Employment Readiness	<input type="checkbox"/>	15 minutes	395	3278.00	3.57	4622471.70	
<b>In-Home Supports Total:</b>							13711064.40
In-Home Supports	<input type="checkbox"/>	15 minutes	438	5049.00	6.20	13711064.40	
<b>Residential Habilitation Total:</b>							27837112.32
Residential Habilitation	<input type="checkbox"/>	1 day	192	288.00	503.42	27837112.32	
<b>Respite Total:</b>							3497480.00
Hourly	<input type="checkbox"/>	15 minutes	200	1700.00	5.41	1839400.00	
Daily	<input type="checkbox"/>	1 day	200	20.00	414.52	1658080.00	
<b>Supported Employment Total:</b>							1708506.72

Supported Employment	<input type="checkbox"/>	15 minutes	304	477.00	9.85	1428328.80	
Long-Term FU	<input type="checkbox"/>	15 minutes	11	4224.00	6.03	280177.92	
<b>Personal Care Services Total:</b>							101517.30
Personal Care Services	<input type="checkbox"/>	15 minutes	5	4482.00	4.53	101517.30	
<b>Skilled Nursing Total:</b>							156210.34
Visit/RN	<input type="checkbox"/>	visit	15	42.00	66.50	41895.00	
Extended/RN	<input type="checkbox"/>	15 minutes	3	3525.00	8.18	86503.50	
Extended/LPN/LVN	<input type="checkbox"/>	15 minutes	2	2716.00	5.12	27811.84	
<b>Behavioral Supports Total:</b>							34601483.95
Diagnostic Assessment	<input type="checkbox"/>	flat rate	165	1.00	251.94	41570.10	
Behavioral Supports	<input type="checkbox"/>	15 minutes	781	2645.00	16.73	34559913.85	
<b>Companion Services Total:</b>							936.00
Companion Services	<input type="checkbox"/>	15 minutes	25	3744.00	0.01	936.00	
<b>Creative Art Therapies Total:</b>							196623.75
Creative Art Therapies	<input type="checkbox"/>	45 minutes	75	5.00	76.73	28773.75	
Arts Therapies (Art Therapy) group	<input type="checkbox"/>	45 minutes	50	60.00	22.38	67140.00	
Arts Therapies (Music Therapy) group	<input type="checkbox"/>	45 minutes	75	60.00	22.38	100710.00	
<b>Dental Total:</b>							46293.12
Dental	<input type="checkbox"/>	visit	564	1.00	82.08	46293.12	
<b>Environmental Accessibilities Adaptations Total:</b>							50000.00
Environmental Accessibilities Adaptations	<input type="checkbox"/>	annual	5	1.00	10000.00	50000.00	
<b>Family Training Total:</b>							121912.00
Caregiver Training, F	<input type="checkbox"/>	15 minutes	51	140.00	15.55	111027.00	
Caregiver Training, N	<input type="checkbox"/>	15 minutes	5	140.00	15.55	10885.00	
<b>Host Home Total:</b>							7396248.65
Host Home	<input type="checkbox"/>	1 day	85	311.00	279.79	7396248.65	
<b>Individualized Day Supports Total:</b>							4461520.00
Individualized Day Individual	<input type="checkbox"/>	15 minutes	250	840.00	9.64	2024400.00	
Individualized Day Group	<input type="checkbox"/>	15 minutes	400	1120.00	5.44	2437120.00	
<b>Occupational Therapy Total:</b>							16038.66

Occupational Therapy	<input type="checkbox"/>	15 minutes	57	11.00	25.58	16038.66	
<b>One-Time Transitional Services Total:</b>							10000.00
One-Time Transitional Services	<input type="checkbox"/>	1 unit	2	1.00	5000.00	10000.00	
<b>Personal Emergency Response System (PERS) Total:</b>							3365.40
Installation and Testing	<input type="checkbox"/>	flat rate	5	6.00	50.00	1500.00	
Monthly Service	<input type="checkbox"/>	flat rate	5	12.00	31.09	1865.40	
<b>Physical Therapy Total:</b>							69986.88
Physical Therapy	<input type="checkbox"/>	15 minutes	114	24.00	25.58	69986.88	
<b>Small Group Supported Employment Total:</b>							367656.96
Small Group Supported Employment	<input type="checkbox"/>	15 minutes	16	4224.00	5.44	367656.96	
<b>Speech, Hearing and Language Services Total:</b>							657508.32
Speech, Hearing and Language Services	<input type="checkbox"/>	15 minutes	216	119.00	25.58	657508.32	
<b>Supported Living with Transportation Total:</b>							58662056.55
Supported Living 1 Res (Periodic) w/ Transportation	<input type="checkbox"/>	15 minutes	105	4992.00	6.85	3590496.00	
Supported Living 3 Res (Basic 1) w/ Transportation	<input type="checkbox"/>	1 day	5	303.00	310.99	471149.85	
Supported Living 3 Res (Basic 2) w/ Transportation	<input type="checkbox"/>	1 day	28	339.00	319.18	3029656.56	
Supported Living 3 Res (Moderate 1) w/ Transportation	<input type="checkbox"/>	1 day	2	240.00	376.46	180700.80	
Supported Living 3 Res (Moderate 2) w/ Transportation	<input type="checkbox"/>	1 day	8	271.00	383.63	831709.84	
Supported Living 3 Res (Intensive 1) w/ Transportation	<input type="checkbox"/>	1 day	38	299.00	446.03	5067792.86	
Supported Living 3 Res (Intensive 2) w/ Transportation	<input type="checkbox"/>	1 day	25	309.00	520.71	4022484.75	
Supported Living 3 Res Intensive w/ LPN w/ Transportation	<input type="checkbox"/>	1 day	6	318.00	624.03	1190649.24	
Supported Living 2 Res (Basic 1) w/ Transportation	<input type="checkbox"/>	1 day	12	238.00	361.12	1031358.72	
Supported Living 2 Res (Basic 2) w/ Transportation	<input type="checkbox"/>	1 day	139	333.00	392.33	18159778.71	
Supported Living 2 Res (Moderate 1) w/ Transportation	<input type="checkbox"/>	1 day	2	365.00	459.33	335310.90	
Supported Living 2 Res (Moderate 2) w/ Transportation	<input type="checkbox"/>	1 day	16	357.00	557.54	3184668.48	

Transportation							
Supported Living 2 Res (Intensive 1) w/ Transportation	<input type="checkbox"/>	1 day	68	246.00	624.03	10438773.84	
Supported Living 1 Res (Asleep Overnt) w/ Transportation	<input type="checkbox"/>	1 day	4	147.00	678.25	398811.00	
Supported Living 1 Res (Awake Overnt) w/ Transportation	<input type="checkbox"/>	1 day	45	205.00	729.40	6728715.00	
<b>Supported Living Total:</b>							63941096.29
Supported Living 1 Res (Periodic)	<input type="checkbox"/>	15 minutes	328	4992.00	6.25	10233600.00	
Supported Living 3 Res (Basic 1)	<input type="checkbox"/>	1 day	5	303.00	290.53	440152.95	
Supported Living 3 Res (Basic 2)	<input type="checkbox"/>	1 day	28	339.00	298.72	2835450.24	
Supported Living 3 Res (Moderate 1)	<input type="checkbox"/>	1 day	2	240.00	356.00	170880.00	
Supported Living 3 Res (Moderate 2)	<input type="checkbox"/>	1 day	8	271.00	362.14	785119.52	
Supported Living 3 Res (Intensive 1)	<input type="checkbox"/>	1 day	38	299.00	425.57	4835326.34	
Supported Living 3 Res (Intensive 2)	<input type="checkbox"/>	1 day	25	309.00	499.22	3856474.50	
Supported Living 3 Intensive w/ LPN	<input type="checkbox"/>	1 day	6	318.00	624.03	1190649.24	
Supported Living 2 Res (Basic 1)	<input type="checkbox"/>	1 day	12	238.00	361.12	1031358.72	
Supported Living 2 Res (Basic 2)	<input type="checkbox"/>	1 day	139	333.00	372.37	17235890.19	
Supported Living 2 Res (Moderate 1)	<input type="checkbox"/>	1 day	2	365.00	438.87	320375.10	
Supported Living 2 Res (Moderate 2)	<input type="checkbox"/>	1 day	16	357.00	537.08	3067800.96	
Supported Living 2 Res (Intensive 1)	<input type="checkbox"/>	1 day	68	246.00	656.77	10986448.56	
Supported Living 1 Res (Asleep Overnt)	<input type="checkbox"/>	1 day	4	147.00	708.94	416856.72	
Supported Living 1 Res (Awake Overnt)	<input type="checkbox"/>	1 day	45	205.00	708.37	6534713.25	
<b>Vehicle Modifications Total:</b>							50000.00
Vehicle Modifications	<input type="checkbox"/>	modification	5	1.00	10000.00	50000.00	
<b>Wellness Services Total:</b>							618692.31
Nutritional Counseling	<input type="checkbox"/>	15 minutes	913	24.00	15.55	340731.60	
Bereavement Counseling	<input type="checkbox"/>	15 minutes	10	18.00	15.35	2763.00	
Massage Therapy	<input type="checkbox"/>	15 minutes	0	0.00	15.55	0.00	
Sexual Education	<input type="checkbox"/>	15 minutes	28	54.00	19.43	29378.16	
Fitness Trainer Individual	<input type="checkbox"/>	15 minutes	85	137.00	12.79	148939.55	
Fitness Trainer Group	<input type="checkbox"/>	15 minutes	200	70.00	6.92	96880.00	
<b>GRAND TOTAL:</b>							244073491.22
Total: Services included in capitation:							

Total: Services not included in capitation:	244073491.22
<b>Total Estimated Unduplicated Participants:</b>	<b>1692</b>
<b>Factor D (Divide total by number of participants):</b>	<b>144251.47</b>
Services included in capitation:	144251.47
Services not included in capitation:	
Average Length of Stay on the Waiver:	357

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (9 of 9)

#### d. Estimate of Factor D.

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 5

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Habilitation Total:</b>							22415671.68
Day Habilitation Individual	<input type="checkbox"/>	15 minutes	80	3411.10	12.36	3372895.68	
Day Habilitation Group	<input type="checkbox"/>	15 minutes	512	4515.00	6.95	16066176.00	
Day Habilitation Sm Facility	<input type="checkbox"/>	15 minutes	100	2200.00	13.53	2976600.00	
<b>Employment Readiness Total:</b>							4792377.00
Employment Readiness	<input type="checkbox"/>	15 minutes	395	3324.00	3.65	4792377.00	
<b>In-Home Supports Total:</b>							14020669.08
In-Home Supports	<input type="checkbox"/>	15 minutes	438	5049.00	6.34	14020669.08	
<b>Residential Habilitation Total:</b>							29041931.52
Residential Habilitation	<input type="checkbox"/>	1 day	192	294.00	514.49	29041931.52	
<b>Respite Total:</b>							3574760.00
Hourly	<input type="checkbox"/>	15 minutes	200	1700.00	5.53	1880200.00	
Daily	<input type="checkbox"/>	1 day	200	20.00	423.64	1694560.00	
<b>Supported Employment Total:</b>							2194560.00
Supported Employment	<input type="checkbox"/>	15 minutes	304	624.00	10.06	1908341.76	
Long-Term FU	<input type="checkbox"/>	15 minutes	11	4224.00	6.16	286218.24	
<b>Personal Care Services Total:</b>							108689.25
Personal Care Services	<input type="checkbox"/>	15 minutes	5	4695.00	4.63	108689.25	

<b>Skilled Nursing Total:</b>							165747.56
Visit/RN	<input type="checkbox"/>	visit	15	48.00	67.96	48931.20	
Extended/RN	<input type="checkbox"/>	15 minutes	3	3525.00	8.36	88407.00	
Extended/LPN/LVN	<input type="checkbox"/>	15 minutes	2	2716.00	5.23	28409.36	
<b>Behavioral Supports Total:</b>							36620554.65
Diagnostic Assessment	<input type="checkbox"/>	flat rate	165	1.00	257.49	42485.85	
Behavioral Supports	<input type="checkbox"/>	15 minutes	780	2744.00	17.09	36578068.80	
<b>Companion Services Total:</b>							936.00
Companion Services	<input type="checkbox"/>	15 minutes	25	3744.00	0.01	936.00	
<b>Creative Art Therapies Total:</b>							201003.75
Creative Art Therapies	<input type="checkbox"/>	45 minutes	75	5.00	78.41	29403.75	
Arts Therapies (Art Therapy) group	<input type="checkbox"/>	45 minutes	50	60.00	22.88	68640.00	
Arts Therapies (Music Therapy) group	<input type="checkbox"/>	45 minutes	75	60.00	22.88	102960.00	
<b>Dental Total:</b>							46293.12
Dental	<input type="checkbox"/>	visit	564	1.00	82.08	46293.12	
<b>Environmental Accessibilities Adaptations Total:</b>							50000.00
Environmental Accessibilities Adaptations	<input type="checkbox"/>	annual	5	1.00	10000.00	50000.00	
<b>Family Training Total:</b>							134365.84
Caregiver Training, F	<input type="checkbox"/>	15 minutes	51	151.00	15.89	122368.89	
Caregiver Training, N	<input type="checkbox"/>	15 minutes	5	151.00	15.89	11996.95	
<b>Host Home Total:</b>							7362640.60
Host Home	<input type="checkbox"/>	1 day	82	314.00	285.95	7362640.60	
<b>Individualized Day Supports Total:</b>							4559380.00
Individualized Day Individual	<input type="checkbox"/>	15 minutes	250	840.00	9.85	2068500.00	
Individualized Day Group	<input type="checkbox"/>	15 minutes	400	1120.00	5.56	2490880.00	
<b>Occupational Therapy Total:</b>							13409.82
Occupational Therapy	<input type="checkbox"/>	15 minutes	57	9.00	26.14	13409.82	
<b>One-Time Transitional Services Total:</b>							10000.00
One-Time Transitional Services	<input type="checkbox"/>	1 unit	2	1.00	5000.00	10000.00	
<b>Personal Emergency Response System</b>							

(PERS) Total:							3406.20
Installation and Testing	<input type="checkbox"/>	flat rate	5	6.00	50.00	1500.00	
Monthly Service	<input type="checkbox"/>	flat rate	5	12.00	31.77	1906.20	
<b>Physical Therapy Total:</b>							71519.04
Physical Therapy	<input type="checkbox"/>	15 minutes	114	24.00	26.14	71519.04	
<b>Small Group Supported Employment Total:</b>							375767.04
Small Group Supported Employment	<input type="checkbox"/>	15 minutes	16	4224.00	5.56	375767.04	
<b>Speech, Hearing and Language Services Total:</b>							677548.80
Speech, Hearing and Language Services	<input type="checkbox"/>	15 minutes	216	120.00	26.14	677548.80	
<b>Supported Living with Transportation Total:</b>							59559994.25
Supported Living 1 Res (Periodic) w/ Transportation	<input type="checkbox"/>	15 minutes	105	4992.00	7.00	3669120.00	
Supported Living 3 Res (Basic 1) w/ Transportation	<input type="checkbox"/>	1 day	5	318.00	317.83	505349.70	
Supported Living 3 Res (Basic 2) w/ Transportation	<input type="checkbox"/>	1 day	28	359.00	326.20	3278962.40	
Supported Living 3 Res (Moderate 1) w/ Transportation	<input type="checkbox"/>	1 day	2	260.00	384.75	200070.00	
Supported Living 3 Res (Moderate 2) w/ Transportation	<input type="checkbox"/>	1 day	8	292.00	392.06	915852.16	
Supported Living 3 Res (Intensive 1) w/ Transportation	<input type="checkbox"/>	1 day	38	306.00	455.84	5300507.52	
Supported Living 3 Res (Intensive 2) w/ Transportation	<input type="checkbox"/>	1 day	12	329.00	532.16	2100967.68	
Supported Living 3 Intensive w/ LPN w/ Transportation	<input type="checkbox"/>	1 day	7	325.00	637.76	1450904.00	
Supported Living 2 Res (Basic 1) w/ Transportation	<input type="checkbox"/>	1 day	12	237.00	369.06	1049606.64	
Supported Living 2 Res (Basic 2) w/ Transportation	<input type="checkbox"/>	1 day	139	347.00	400.96	19339503.68	
Supported Living 2 Res (Moderate 1) w/ Transportation	<input type="checkbox"/>	1 day	2	365.00	469.43	342683.90	
Supported Living 2 Res (Moderate 2) w/ Transportation	<input type="checkbox"/>	1 day	16	365.00	569.80	3327632.00	
Supported Living 2 Res (Intensive 1) w/ Transportation	<input type="checkbox"/>	1 day	68	252.00	637.76	10928655.36	
Supported Living 1 Res (Asleep Overnt) w/ Transportation	<input type="checkbox"/>	1 day	4	147.00	693.17	407583.96	
Supported Living 1							



Res (Awake Overnt) w/ Transportation	<input type="checkbox"/>	1 day	45	201.00	745.45	6742595.25	
<b>Supported Living Total:</b>							64994169.55
Supported Living 1 Res (Periodic)	<input type="checkbox"/>	15 minutes	328	4992.00	6.39	10462832.64	
Supported Living 3 Res (Basic 1)	<input type="checkbox"/>	1 day	5	318.00	296.92	472102.80	
Supported Living 3 Res (Basic 2)	<input type="checkbox"/>	1 day	28	359.00	305.29	3068775.08	
Supported Living 3 Res (Moderate 1)	<input type="checkbox"/>	1 day	2	260.00	363.84	189196.80	
Supported Living 3 Res (Moderate 2)	<input type="checkbox"/>	1 day	8	292.00	370.11	864576.96	
Supported Living 3 Res (Intensive 1)	<input type="checkbox"/>	1 day	38	306.00	434.93	5057366.04	
Supported Living 3 Res (Intensive 2)	<input type="checkbox"/>	1 day	12	329.00	510.21	2014309.08	
Supported Living 3 Intensive w/ LPN	<input type="checkbox"/>	1 day	7	325.00	637.76	1450904.00	
Supported Living 2 Res (Basic 1)	<input type="checkbox"/>	1 day	12	237.00	369.06	1049606.64	
Supported Living 2 Res (Basic 2)	<input type="checkbox"/>	1 day	139	347.00	380.56	18355550.48	
Supported Living 2 Res (Moderate 1)	<input type="checkbox"/>	1 day	2	365.00	448.52	327419.60	
Supported Living 2 Res (Moderate 2)	<input type="checkbox"/>	1 day	16	365.00	548.89	3205517.60	
Supported Living 2 Res (Intensive 1)	<input type="checkbox"/>	1 day	68	252.00	671.21	11501854.56	
Supported Living 1 Res (Asleep Overnt)	<input type="checkbox"/>	1 day	4	147.00	724.54	426029.52	
Supported Living 1 Res (Awake Overnt)	<input type="checkbox"/>	1 day	45	201.00	723.95	6548127.75	
<b>Vehicle Modifications Total:</b>							50000.00
Vehicle Modifications	<input type="checkbox"/>	modification	5	1.00	10000.00	50000.00	
<b>Wellness Services Total:</b>							646641.08
Nutritional Counseling	<input type="checkbox"/>	15 minutes	913	24.00	15.89	348181.68	
Bereavement Counseling	<input type="checkbox"/>	15 minutes	10	18.00	15.68	2822.40	
Massage Therapy	<input type="checkbox"/>	15 minutes	0	0.00	15.89	0.00	
Sexual Education	<input type="checkbox"/>	15 minutes	28	58.00	19.85	32236.40	
Fitness Trainer Individual	<input type="checkbox"/>	15 minutes	85	148.00	13.07	164420.60	
Fitness Trainer Group	<input type="checkbox"/>	15 minutes	200	70.00	7.07	98980.00	
<b>GRAND TOTAL:</b>						251692035.83	
Total: Services included in capitation:							
Total: Services not included in capitation:						251692035.83	
<b>Total Estimated Unduplicated Participants:</b>						1692	
<b>Factor D (Divide total by number of participants):</b>						148754.16	
Services included in capitation:							
Services not included in capitation:						148754.16	
<b>Average Length of Stay on the Waiver:</b>						357	