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State/Territory Name: District of Columbia

State Plan Amendment (SPA) #: DC-14-04

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

Region III/Division of Medicaid and Children's Health Operations
SWIFT # 123120144017

FEB 19 2015

Claudia Schlosberg, J.D.
Acting Senior Deputy Director/State Medicaid Director
Department of Health Care Finance
441 4th Street, N.W., 9th Floor
Washington, D.C. 20001

Dear Ms. Schlosberg:

Enclosed is a copy of the approved State Plan Amendment (SPA) Transmittal Number 14-004. This SPA adds Adult Day Health Programs (ADHP) as a 1915(i) Home and Community-Based Services (HCBS) benefit for individuals age 55 or older who have one or more chronic conditions or progressive illnesses as diagnosed by a physician. The effective date for this amendment is April 1, 2015. The CMS-179 and the approved State Plan pages are enclosed.

Since the District has elected to target the population who can receive these section 1915(i) State plan HCBS, CMS approves this SPA for a five-year period in accordance with Section 1915(i)(7) of the Act and 42 CFR 441.745(a)(2)(vi)(A). The District will be able to renew this SPA for an additional five-year period if CMS determines, prior to the beginning of the renewal period, that the District met Federal requirements and that the District's monitoring is in accordance with the quality improvement strategy specified in the approved SPA. To renew State Plan HCBS for an additional five-year period, the District must provide a written request for renewal to CMS at least 180 days prior to the end of the approval period.

We appreciate the cooperation and effort provided by your staff throughout this process. If you have any questions about this SPA, please contact Kia Banton of my staff at 215-861-4252, or via email at Kia.Banton@cms.hhs.gov.

Sincerely,

Associate Regional Administrator

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **14-004**

2. STATE: District of Columbia

3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act

TO: Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

4. PROPOSED EFFECTIVE DATE
April 1, 2015

5. TYPE OF PLAN MATERIAL *(Check One)*:

☒ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
1915 (i) of the Social Security Act

7. FEDERAL BUDGET IMPACT
a. FFY 15 $ 2,950,000
b. FFY 16 $ 6,100,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Supplement 1 to Attachment 3.1-A pp. 35-67
Attachment 4.19 B pp. 29-35

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

New

10. SUBJECT OF AMENDMENT:

1915 (i) State Plan Home and Community-Based Services Option

11. GOVERNOR'S REVIEW *(Check One)*
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Resolution Number: B20-199

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
Claudia Schlosberg J.D.

14. TITLE
Interim Senior Deputy Director/Medicaid Director

15. DATE SUBMITTED
April 25, 2014

16. RETURN TO

Claudia Schlosberg, J.D.
Interim Senior Deputy Director/Medicaid Director
Department of Health Care Finance
441 4th Street, NW, 9th Floor, South
Washington, DC 20001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
November 26, 2014

18. DATE APPROVED FEB 10 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
April 1, 2015

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME
Francis McCullough

22. TITLE
Associate Regional Administrator

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

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

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

Adult Day Health Program (ADHP) Services

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

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

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

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

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

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

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

Eligibility evaluation is a two-step process. Function # 3) Medicaid non-financial eligibility determinations are performed by DHCF's Long Term Care Services and Supports (LTCSS) Contractor. Medicaid financial eligibility determinations are performed by the Department of Human Services' Economic Security Administration.

Individuals enrolled as Medicaid beneficiaries at the time of the ADHP service request will be subject to the non-financial eligibility determinations performed by DHCF's LTCSS Contractor and for a review of financial eligibility.

Function # 5) Prior authorizations for State Plan HCBS Services is performed by DHCF's LTCSS Contractor. Once an applicant requests the receipt of Long-term Care Services and Supports (LTCSS) , DHCF's LTCSS Contractor, will conduct a face-to -face assessment of the individual's physical, cognitive and behavioral health care and support needs, strengths and preferences, available service and housing options and availability of unpaid caregiver support to determine the individual's level of care (LOC) for long-term care services and supports. This assessment process to determine non-financial eligibility is also the prior authorization of State Plan HCBS services. The assessment process uses a standardized assessment tool and results in a numerical score that identifies the individual's level of need.

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

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

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

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

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

Number Served

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

Annual Period	From	To	Projected Number of Participants
Year 1	April 2015	April 2016	569
Year 2	April 2016	April 2017	585
Year 3	April 2017	April 2018	601
Year 4	April 2018	April 2019	617
Year 5	April 2019	April 2020	634

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

Financial Eligibility

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

2. **Income Limits.**

☐ In addition to providing State plan HCBS to individuals described in item 1 above the State is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for home and community-based services under the needs-based criteria established under 1915(i)(1)(A) or who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d), (e), or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income federal benefit rate. (*Select one*):

☐ The State covers all of the individuals described in item 2(a) and (b) as described below. (*Complete 2(a) and 2(b)*)

☐ The State covers only the following group of individuals described below. (*Complete 2(a) or 2(b)*)

2. (a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria for the 1915(i) benefit, have income that does not exceed 150% of the federal poverty line, and will receive 1915(i) State plan HCBS.

Methodology used (*Select one*):
☐ AFDC
☐ SSI
☐ OTHER (*Describe*):

For States that have elected the AFDC or the SSI methodology, the State uses the following less restrictive 1902(r)(2) income disregards for this group. There is no resource test for this group. (*Specify*):

2.(b) Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d), (e), or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income federal benefit rate. For individuals eligible for 1915(c), (d), or (e) waiver services, this amount must be the same amount as the income standard specified under your State plan for the special income level group. For individuals eligible for 1915(c)-like services under an approved 1115, this amount must be the same as the amount of the income standard used for individuals found eligible using institutional eligibility rules. (*Select one*):

☐ 300% of the SSI/FBR
☐ (*Specify*) _____% Less than 300% of the SSI/FBR

(*Select one*):
☐ Specify the 1915(c) waiver/waivers CMS base control number/numbers for which the individual would be eligible:

☐ Specify the name(s) or number(s) of the 1115 waiver(s) for which the individual would be eligible:

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

✓	The State does not provide State plan HCBS to the medically needy.	
	The State provides State plan HCBS to the medically needy *(select one):*	
	○	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a State makes this election, medically needy individuals only receive 1915(i) services.
	✓	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

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

○	Directly by the Medicaid agency
✓	By Other (*specify State agency or entity under contract with the State Medicaid agency*):
	The DHCF's LTCSS Contractor, will perform evaluations and reevaluations to determine eligibility for all Long-Term Care Services and Supports (LTCSS) programs. In particular, the initial face-to-face assessment will assess the participant's level of need for all LTCSS including the State Plan HCBS benefit by using a standardized assessment tool. The LTCSS Contractor will also perform reevaluations at least once every twelve (12) month period, or whenever there is a significant change to the person's health and/or service's needs.

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

Initial assessments and reassessments will be conducted by a registered nurse employed by the DHCF's LTCSS Contractor. The registered nurse will meet all of the licensure requirements prescribed by the District of Columbia Department of Health's Board of Nursing under the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1205.01).

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

The needs-based criteria for the State Plan HCBS benefit, including ADHP services, will be determined by DHCF's designated LTCSS Contractor. The LTCSS Contractor will receive requests for various long term care services and supports; verify applicant eligibility for Medicaid; and assess the need for services using a standardized assessment tool. As noted above, assessments and reassessments will be conducted in-person by a registered nurse employed by the DHCF's LTCSS Contractor using a standardized assessment tool that has been designed and validated for all long-term care populations. The tool identities a beneficiary's needs across multiple domains including functional, clinical, and behavioral (see Answer 5, Needs-based HCBS Eligibility Criteria below). Reassessments will also be conducted by an RN with the same assessment tool at least once every twelve (12) months, or whenever there is a significant change to the person's health and/or service needs.

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

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

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

The needs-based criteria are determined by a standardized assessment tool which will include an assessment of the individual's support needs across three domains including: (1) functional; (2) clinical; and (3) behavioral.

1) Functional- impairments including assistance with activities of daily living such as bathing, dressing, eating/feeding;
2) Clinical supports-skilled nursing or other skilled care (e.g., wound care, infusions), sensory impairments, other health diagnoses; and
3) Behavioral- ability to understand others, communications impairments, presence of behavioral symptoms like hallucinations, and/or delusions.

Completion of the assessment will yield a final total score determined by adding up the individual scores from the three domains.
To be eligible for reimbursement of 1915(i) ADHP services, an individual has to obtain a minimum score of four (4) on the assessment tool for acuity level 1 services, and a score of six (6) or higher for acuity level 2 services.

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

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
The needs-based criteria are determined	Effective on or after the date of the promulgation	Individuals who qualify for ICF/MR services will not be assessed via DHCF's	Individuals who are admitted to the hospital are

by a standardized assessment tool which will include an assessment of the individual's support needs across three domains including: (1) functional; (2) clinical; and (3) behavioral. 1) Functional-impairments including assistance with activities of daily living such as bathing, dressing, eating/feeding; 2) Clinical supports-skilled nursing or other skilled care (e.g., wound care, infusions), sensory impairments, other health diagnoses; and 3) Behavioral-ability to understand others, communications impairments, presence of behavioral symptoms like	of the Long-Term Care Assessment Process rulemaking, an individual who is a new admission shall be eligible for nursing facility services if they obtain a total score of nine (9) or more on the assessment tool. This is a more stringent standard than what is currently being used to determine eligibility for nursing facility admissions.	LTCSS assessment tool. To determine if an individual requires services furnished by an ICF/MR, assessments are conducted by DHCF's Quality Improvement Organization (QIO) via the DC Level of Need (LON) which is a comprehensive assessment tool to determine the level of care criteria for ICF/MR services. A person shall meet a level of care determination if one of the following criteria has been met: (a) The person's primary disability is an intellectual disability (ID) with an intelligence quotient (IQ) of fifty-nine (59) or less; (b) The person's primary disability is an ID with an IQ of sixty (60) to sixty nine (69) and the person has at least one (1) of the following medical conditions: (1) Mobility deficits; (2) Sensory deficits; (3) Chronic health problems; (4) Behavior	considered acute care patients. There is no applicable waiver for individuals who meet a hospital LOC. The State Medicaid Agency (SMA) contracts with a Quality Improvement Organization (QIO), Qualis Health, to prior authorize hospital admissions for Medicaid beneficiaries who are in need of inpatient hospital services based on medical necessity criteria.

hallucinations, and/or delusions. Completion of the assessment will yield a final total score determined by adding up the individual scores from the three domains. To be eligible for reimbursement of 1915(i) ADHP services, an individual has to obtain a minimum score of four (4) on the assessment tool for acuity level 1 services, and a score of six (6) or higher for acuity level 2 services.		problems; (5) Autism; (6) Cerebral Palsy; (7) Epilepsy; or (8) Spina Bifida. (c) The person's primary disability is an ID with an IQ of sixty (60) to sixty-nine (69) and the person has severe functional limitations in at least three of the following major life activities: (1) Self-care; (2) Understanding and use of language; (3) Functional academics; (4) Social Skills; (5) Mobility; (6) Self-direction; (7) Capacity for independent living; or (8) Health and Safety. (d) The person has an ID, has severe functional limitations in at least three (3) of the major life activities set forth in (c) (1) through (c)8 (see above); and has one (1) of the following diagnoses: (1) Autism;	

		(2) Cerebral Palsy; (3) Prader Willi; or (4) Spina Bifida.	

*Long Term Care/Chronic Care Hospital

7. ☑ **Target Group(s).** The State elects to target this 1915(i) State plan HCBS benefit to a specific population. With this election, the State will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the State may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C). (*Specify target group(s)*):

Individuals enrolled in the 1915 (i) program shall:

(1) Be age 55 or older; and

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

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

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

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

The District will ensure that the ADHP day settings and participants attending the ADHP day settings are living in residential settings that comply with the mandates of 42 CFR 441.710.

ADHP settings must be compliant with all of the day setting requirements under the regulation. The SMA will ensure this through its Provider Readiness Review (PRR) process, and on-site reviews.

In order to qualify to be an ADHP provider, a provider must meet the criteria under the PRR process. The Prospective Provider Application checklist is a tool used by the SMA to measure a provider's readiness to provide ADHP services. It also ensures that the providers have developed the appropriate policies, health and welfare standards, and staffing and

personnel training plans to be enrolled as an ADHP provider. The SMA amended its Prospective Provider Application checklist by incorporating elements to ensure that the ADHP settings will meet the qualifications of a home and community-based setting as described under 42 CFR 441.710. Specifically, each ADHP provider setting must have all of following qualities, and such other qualities as the Secretary deems appropriate, based on the needs of the ADHP participant as determined by the needs in their person-centered plan of care.

These include the following:

1) The setting is integrated in and supports full access of individuals receiving ADHP services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid home and community-based services.

2) The setting is selected by the individual from among setting options, including non-disablity specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

3) The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint

4) The setting optimizes, but does not regiment, individual inititative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact; and

5) The setting facilitates individual choice regarding services and supports, and who provides them.

The SMA will ensure that each ADHP provider meets the criteria described in the Prospective Provider Application checklist before it is enrolled as an ADHP provider through the PPR process. Specifcially, the SMA will use its its monitoring team to review each ADHP setting on a case-by-case basis to ensure that it meets the characteristics of the HCBS settings described at 42 CFR 441.710. This review will be initiated during the provider readiness review and enrollment process, when a provider submits an application to be enrolled. The amended Prospective Provider Application Checklist is attached. These reviews will also be conducted periodically as part of the SMA's quality assurance process.

Although this SPA does not include any residential services, and the SMA does not pay for or regulate residential services, the SMA will also ensure that participants receiving ADHP

services are living in settings that comply with 42 CFR 441.710. First, individuals residing in non-HCBS settings including nursing facilities, hospitals, intermediate care facilities for persons with intellectual/developmental disabilities and institutions for mental diseases are not eligible to receive ADHP services.

Second, with respect to individuals who are residing in other, provider –owned, residential settings, DHCF conducted a legal analysis of the laws, and rules governing licensure of these facilities. Many of these existing laws and regulations offer similar protections to the federal requirements prescribed under the final HBS rulemaking.

Although current District regulations governing community residence facilities do not fully comport with CMS HCBS settings requirements, providers may exceed licensure standards. Therefore, the District will utilize an additional individual assessment process to ensure that the participants seeking to enroll in the ADHP settings are living in settings that comply with the provisions of the federal regulation. Specifically, DHCF uses nurses to conduct face-to-face, conflict free, standardized assessments of applicants seeking long-term care services and supports to determine the applicant's level of need for services. Currently, as part of the assessment process, these nurses evaluate the applicant's living environment for safety and cleanliness. DHCF will expand the scope of the assessment to capture additional information from the individual seeking services to ensure that the individual is living in an environment that comports with both the HCBS quality standards and the additional standards that pertain to provider-owned or controlled residential settings as set forth in 42 CFR Section 441.710 . Administration of the assessment process ensures that individuals accessing ADHP services live in settings that promote community living.

The additional information to be gathered from the individual assessment process to ensure compliance with the federal law shall include the quality standards that pertain to all HCBS state plan settings as set forth above and the following:

1) The individual will have a lease or other legally enforceable agreement providing similar protections;
2) The individual will have privacy in their unit, including lockable doors, choice of roommates and freedom to furnish and decorate the unit;
3) The individual will have control over his/her own schedule including access to food at any time;
4) The individual will be permitted to have visitors at any time; and
5) The setting will be physically accessible.

The additional requirements of 42 CFR 441.710 must also be met:

a) If the particiant does not have a lease, the specific unit/dwelling is owned, rented, or occupied under legally enforceable agreement;
b) The agreement has the same responsibilities/protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity;
c) If tenant laws do not apply, state ensures lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;
d) Each individual has privacy in their sleeping or living unit;
e) Units have lockable entrance doors, with the individual and appropriate staff having keys to doors as needed;
f) Individuals sharing units have a choice of roommates;
g) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement;
h) Individuals have freedom and support to control their schedules and activities and have access to food any time;
i) Individuals may have visitors at any time; and
j) Setting is physically accessible to the individual.

Modifications of the additional requirements must be:

a) Supported by specific assessed need;
b) Justified in the person-centered service plan; and
c) Documented in the person-centered service plan.

Lastly, documentation in the person-centered service plan of the modifications must include the following:

a) Specific individualized assessed need;
b) Prior interventions and supports including less intrusive methods;
c) Description of condition proportionate to assessed need;
d) Ongoing data measuring effectiveness of modification;
e) Established time limits for periodic review of modifications;
f) Individual's informed consent; and
g) Assurance that interventions and supports will not cause harm.

ADHP participants will be re-assessed to determine their need for services at least every twelve months or when there is a significant change in their condition. Upon re-assessment, the individual assessment process will be conducted to ensure that all the setting requirements prescribed under the federal regulation continue to be met.

Person-Centered Planning & Service Delivery

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

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

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

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

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

   The face-to-face assessment will be performed by an RN employed by DHCF's LTCSS Contractor. The staff performing the assessment will be licensed health care professionals trained in assessment of individuals with physical, cognitive, or mental conditions that trigger a potential for HCBS services and supports.

   Each RN will be licensed or authorized to practice registered nursing pursuant to qualifications prescribed by the District of Columbia Department of Health, Health Occupation and Regulations Act.

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

The Aging, Disability, and Resource Center (ADRC), through an MOU with DHCF, will be responsible for for developing the person-centered plan of care. The person-centered plans of care will be developed in consultation with the beneficiary, the beneficiary's guardian or representative, and any other person(s) chosen by the individual. Staff and agents performing person-centered plans of care will have current knowledge of available resources, services options and providers and will be knowledgeable regarding best practices to improve health and quality of life outcomes.

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

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

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

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

DHCF's designated LTCSS Contractor shall conduct the individual, face to face assessment and provide information to the individual regarding all services for which they qualified based upon their assessed needs. Initially, the person will be given a choice of

providers at the ADRC to select a choice of 1915 (i) ADHP Provider. Additionally, once the person is at the ADHP provider site, a designated staff person will have primary responsibility for developing a written plan to implement each person's plan of care. In doing so, the staff person will play an essential role in assisting persons to learn about the various professionals offering supports and services at the provider site, and selecting a qualified provider to deliver their services. In this way, participants will exercise their freedom of choice as it relates to which providers and professionals to select to obtain ADHP services and supports. If additional options counseling is needed or desired, the designated LTCSS Contractor will refer the person to the Aging and Disability Resource Center (ADRC) for information regarding available services and to obtain information about qualified providers. ADRC staff will offer options counseling to persons who desire assistance to select a qualified provider.

8. **Process for Making Plan of Care Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

The SMA will review each person-centered plan of care as part of their administrative authority.

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

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

Services

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Adult Day Health Services Program or (ADHP)
Service Definition (Scope):	
ADHPs provide essential services including social service supports, therapeutic activities meals, medication administration, and transportation to therapeutic activities for adults, age fifty-five (55) and over, during the day, in a safe community setting outside of his or her home. Each community setting will be enrolled as a Medicaid provider of ADHP services. Adult day health includes the following services: medical and nursing consultation services including health counseling to improve the health, safety and psycho-social needs of participants; individual and group therapeutic activities, including social, recreational and educational activities provided by licensed therapists such as an occupational or physical therapist, and speech language pathologist; social service supports provided by a social service professional including consultations to determine the individual's need for services, offering guidance through counseling and teaching on matters related to the person's health, safety, and general welfare; direct care supports services to provide direct supports like personal care assistance, offering guidance in performing self-care and activities of daily living, instruction on accident prevention and the use of special aides; and medication administration services provided by a Registered Nurse (RN) including administration of medication and/or assistance in self administration of medication as appropriate. Participants will also be provided with nutrition and meal services consisting of nutritional education, training, and counseling to participants and their families, and provision of meals and snacks while in attendance at the ADHP setting. All services will be paid for through bundled per-diem rates. Each participant will receive services based upon their strength, preferences and health care needs as reflected by their level of need and person-centered plan. Recognizing that some participants may have more complex needs (such as a greater need for supervision or support), DHCF has developed two reimbursement rates – one for those who meet the threshold eligibility criteria based upon their assessed needs (Acuity level 1) and the other, for those whose assessed needs are higher (Acuity level 2). The enhanced rates recognize that staffing levels must increase when participants have higher acuity levels.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
✓	Categorically needy *(specify limits):*
	N/A
✓	Medically needy *(specify limits):*
	N/A

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Adult Day Health Program	The provider shall meet more specific provider qualification standards in accordance with District regulations.	Each Provider shall meet the following standards set by the SMA: (1) Submit a Medicaid Provider Application to SMA to be enrolled as an ADHP provider and maintain a Medicaid Provider Agreement; (2) Have a valid Certificate of Need (CON) as determined by the District of Columbia State Health Planning and Development Agency. (3) Meet the SMA's Provider Readiness Review process which will ensure that the following are in place: (a) A service delivery plan to render delivery of ADHP	Each ADHP shall maintain minimum insurance coverage as follows: • Blanket malpractice insurance for all employees in the amount of at least one million dollars ($1,000,000) per incident; • General liability insurance covering personal property damages, bodily injury, libel and slander of at least one million ($1,000,000) per occurrence; and Product liability insurance, when applicable

		services; (b) A staffing and personnel training plan in accordance with any SMA requirement; and (c) Policies and procedures in accordance with any requirements set by the SMA.	

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

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

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

☐	Participant-directed	✓	Provider managed

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

Participant-Direction of Services

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

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

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

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

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

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

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

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

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

O	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
O	Financial Management is furnished as a Medicaid administrative activity necessary for

administration of the Medicaid State plan.

6. ☐ **Participant–Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans, that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

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

7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). *(Select one):*

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

b. Participant–Budget Authority (individual directs a budget). *(Select one):*

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

Quality Improvement Strategy

(Describe the State's quality improvement strategy in the tables below):

The proposed Quality Improvement Strategy contains monitoring and oversight efforts written to address the level of activity that may be appropriate to the ADHP's time in existence. Within one (1) year of operation, the SMA shall evaluate the Program and determine the appropriateness of expanding the SMA's monitoring and oversight efforts.

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Data Metrics)*	**Discovery Activity (Source of Data)**	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Monitoring Responsibilities** *(Who analyzes and aggregates remediation activities)*	**Frequency** *of Analysis and Aggregation*
Service plans address assessed needs of enrolled participants, are updated annually, and document choice of services and providers.	**PM.1** Each Person-Centered Plan of Care is updated annually and documents the individual's choice of services and providers. *Numerator: Number of Person-Centered Plans of Care that document the individual's choice of services and providers.* *Denominator: Number of Person-Centered Plans of Care due.*	Individual Plan of Care	Provider	Quarterly	SMA	Annually

	PM. 2 Individuals receive services described in their Person-Centered Plan of Care. *Numerator: Number of individuals receiving services as described in their Person-Centered Plan of Care.* *Denominator: Number of individuals required to have prescribed Person-Centered Plans of Care*					
	PM. 3. Individuals receive a face: face conflict-free assessment to determine eligibility. *Numerator: Number of individuals meeting eligibility requirements.* *Denominator: Number of individuals enrolled in an Adult Day Health Program.*					

Providers meet required qualifications.	**PM. 1** Licensed clinicians meet initial licensure requirements. *Numerator: Number of licensed clinicians with appropriate credentials.* *Denominator: Number of licensed clinicians eligible to provide services.*					
	PM. 2 Licensed clinicians continue to meet applicable licensure requirements under the District of Columbia, Department of Health's, Health Occupation and Revision Act of 2009, promulgated by the Department of Health's Occupational and Licensing Administration. *Numerator: Number of licensed clinicians with appropriate credentials.* *Denominator: Number of licensed clinicians required to be certified.*	Training Records	Provider	Quarterly	SMA	Annually
	PM. 3 Provider agencies continue to meet applicable certification standards. *Numerator: Number of providers that continue to meet applicable certification standards.* *Denominator: Number of providers subject to certification.*	Findings from monitoring tools	SMA	Annually	SMA	Annually

	PM. 4 Staff receives orientation within 30 days of hire. *Numerator: Number of new staff trained within 30 days of hire.* *Denominator: Number of new staff.*	Training Records	SMA	Annually	SMA	Annually
	PM. 5 Staff receive ongoing training according to requirements outlined in program rules. *Numerator: Number of staff trained according to requirements.* *Denominator: Number of staff required to be trained.*					
The SMA retains authority and responsibility for program operations and oversight.	**PM. 1** Providers comply with requirements outlined in program rules under Section 9702, Provider Qualifications. *Numerator: Number of providers meeting requirements outlined in program rules.* *Denominator: Number of providers' records reviewed.*	Provider Records	SMA	Annually	SMA	Annually
	PM. 2 Providers are approved to offer services. *Numerator: Number of provider approved to offered services.*	Provider Applications	SMA	Annually	SMA	Annually

	Denominator: Number of provider applications submitted.					
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to enrolled participants by qualified providers.	**PM. 1** Percentage of prior authorizations issued timely. *Numerator: Number of prior authorizations issued within required time frame.* *Denominator: Number of prior authorizations issued by provider.*	MMIS – Claims Data	SMA	Quarterly	SMA	Quarterly
	PM. 2 Percentage of claims paid timely. *Numerator: Number of claims paid according to requirement.* *Denominator: Number of claims submitted for payment.*					
	PM. 3 Claims are paid in accordance with 1915(i) services rendered by 1915(i) providers. *Numerator: Number of claims paid according to requirement.* *Denominator: Number of claims submitted for payment.*					
	PM. 4 Claims are reviewed by Program Integrity audits that fail audit standards. *Numerator: Number of audited claims that fail audit standards.*					

	Denominator: Number of claims selected monthly for auditing.					
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	**PM. 1** Incidents are reported within 24 hours or the next business day. *Numerator: Number of incidents related to abuse, neglect and exploitation.* *Denominator: Number of incidents reported within 24 hours.*	Incident Reports	Provider	Monthly	SMA	Quarterly
	PM. 2 Allegations of abuse, neglect, and exploitation incidents are investigated by provider. *Numerator: Number of incidents related to allegation of abuse, neglect and exploitation.* *Denominator: Number of allegation of abuse, neglect incidents investigated.*					
The State retains authority and responsibility for ensuring that all settings (residential and non-residential) meet the requirements prescribed under 42 CFR 441.710	**PM1.** Individuals receiving Adult Day Health Program services reside in settings that comply with requirements outlined in 42 CFR 441.710 *Numerator: No. of residential settings meeting requirements outlined in federal rules* *Denominator: Total number of residential settings reviewed to determine compliance*	Provider Reports	SMA	Quarterly	SMA	Annually

	PM2. Adult Day Health services are delivered in settings that comply with requirements outlined in 42 CFR 441.710 *Numerator: No. of day settings meeting requirements outlined in federal rules* *Denominator: Total number of Adult Day health settings reviewed to determine compliance*	Provider Readiness Review Data	SMA	Initially	SMA	Annually
	PM3. Participants receiving Adult Day Health Services reside in settings that comply with requirements outlined in 42 CFR 441.710 per the Provider Readiness Review process *Numerator: Number of participants' residential settings that comply with the federal requirements per the Prospective Provider Application Tool* *Denominator: Total number of participant residential settings assessed via the Prospective Provider Application Tool*	Provider Readiness Review Data	SMA	Initially	SMA	Annually

System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
• The provider will be required to establish and maintain a comprehensive quality assurance program, for the purpose of evaluating its program strengths and needs. Program strengths and needs will be identified through the ongoing collection and analysis of data, and remediation activities. • The SMA will conduct site visits, review documents, interview staff and individuals, in an effort to verify the effectiveness of systems the provider has in place. The SMA will notify providers of any actual or potential individual or systems problems. The provider will analyze the SMA's findings to develop and take correction actions. The SMA then examines the outcomes of corrective action to measure the effectiveness of the providers' corrective action and the need to prioritize areas in need of improvement.	SMA/Provider	Ongoing/ Continuously	• As part of its Quality Improvement Strategy, the State Medicaid Agency proposes to work collaboratively with the provider to examine systems, identify issues, evaluate factors impacting the delivery of services, design corrective actions and measure the success of system improvement. The SMA has primary day to day responsibility for assuring that there is an effective and efficient quality management system is in place. The SMA will work with internal and external stakeholders and make recommendations regarding enhancements to the quality management system on an ongoing basis. • The focus of system improvement will be on the discovery of issues, remediation, monitoring action taken, and making system improvement when necessary. Information gathered at the individual and provider level will be used to remedy situations on those levels and to inform overall system performance and improvements. • On an annual basis, the provider will submit a program evaluation report which summarizes program and operational performance throughout the year. Based on the data contained in the report, input from stakeholders and the outcome of monitoring activities conducted by the SMA, the SMA will evaluate key performance measures indicators and the

			provider's quality management system. Results of this evaluation may demonstrate a need to change performance indicators, including changing priorities; using different approaches to ensure progress; modifying roles and responsibilities, and data sources in order to obtain the information needed for system changes. • Upon identification of deficiencies the provider will be required to implement satisfactory improvements within timeframe identified by SMA. Each deficiency may require different timelines based on the impact the deficiency has on the delivery of services. Providers will be notified of deficiencies during face: face meetings, by email or through the SMA documentation, and submission of a discovery/remediation tool.

Methods and Standards for Establishing Payment Rates

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

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
■■	HCBS Adult Day Health-

Reimbursement for adult day health services associated with the 1915(i) HCBS State Plan Option and defined per Attachment 3.1-A page 35 shall be paid based upon uniform per-diem rates at two acuity levels.

Acuity level 1 will be reimbursed at ninety eight dollars and seventy cents ($98.70).

Acuity level 2 will be reimbursed at one hundred and twenty five dollars and seventy eight cents ($125.78).

The agency's fee schedule rate was set as of 4/1/2015 and is effective for services provided on or after that date. All rates are published on the agency's website at www.dhcf.dc.gov. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the DHCF Provider Web Portal available at www.dc.medicaid.com/dcwebportal/nonsecure/feeScheduleDownload.

ADHP will be reimbursed at two different acuity levels. To be eligible for reimbursement at acuity level 1 ADHP services, an individual shall obtain a total score of four (4) or five (5). To be eligible for reimbursement at acuity level 2 ADHP services, an individual shall obtain a total score of six (6) or higher. The specific acuity level does not affect the benefit package received by an individual. ADHP consists of one set of services that are available to all participants, regardless of acuity level. Each participant will receive services based upon their strength, preferences and health care needs as reflected by their level of need and person-centered plan. Recognizing that some participants may have more complex needs (such as a greater need for supervision or support), DHCF has developed two reimbursement rates – one for those who meet the threshold eligibility criteria based upon their assessed needs and the other, for those whose assessed needs are higher. The enhanced rates recognize that staffing levels must increase when participants have higher acuity levels.

Adult Day Health providers are defined per the 1915(i) HCBS per Supplement 1, Attachment 3.1-A, pages 55 and 56. Reimbursement for adult day health services is paid using two bundled per-diem rates that are reasonable and adequate to meet the costs incurred by an efficient and economically prudent provider. The bundled per-diem rate consists of staffing costs in addition to program materials, indirect costs, and administrative costs. Room and board are excluded in the per-diem rates.

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

For FY 2016 and annually thereafter, the per-diem rates will be inflated by the corresponding CMS Market Basket Index for Nursing Facilities for that period.

DHCF intends to rebase the per-diem reimbursement rates using submitted cost-reports from FY 2016, and based on a revised reimbursement methodology to be developed by DHCF. DHCF shall submit and seek CMS approval of a new State Plan Amendment prior to effectuating these new rates and revised payment methodology. DHCF anticipates that the new approved rates and payment methodology will become effective in FY 2018.

Staffing, wages, and benefits

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

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

	Base wage or salary	Hours on duty per fiscal year	Ratio of staff member to beneficiaries	Number of operating days	Marginal addition for fringe benefits
Direct support	Based on DC	2080 (FTE) plus 80 hours	1:10 in Acuity 1; 1:4	260 (fiscal year,	20%

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

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

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

Program materials, indirect costs, and administrative costs

In addition to the staffing component, the rate includes additional funding for program materials, supplies, and indirect costs, including: (1) programming supplies; (2) food and snack costs; (3) indirect costs such as rental and building maintenance costs, utilities, telecommunications, and transportation; and (4) staff training and quality management. The estimate of these costs were based in part on qualitative data collection conducted in meetings, site visits, and phone calls with existing District health care providers, and in part on similar cost categories as reported by existing District provides via cost reporting. Annualized costs were translated into per-diem, per-beneficiary rates using an expected operating year of 260 days and expected program size of 40 beneficiaries.

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

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

Service Limitations

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

(a) Day Habilitation and Individualized Day Supports under the 1915 (c) Waiver for Individuals with Intellectual and Developmental Disabilities (ID/DD);

(b) Intensive day treatment or day treatment mental health rehabilitative services (MHRS);

	(c) Personal Care Aide services; (State Plan and 1915 (c) waivers), or (d) Services funded by the Older Americans Act of 1965, Title IV, Public Law 89-73, 79 Stat. 218, as amended; Public Law 97-115, 95 Stat. 1595; Public Law 98-459, 98 Stat. 1767; Public Law 100-175; Public Law 100-628, 42 U.S.C. 3031-3037b; Public Law 102-375; Public Law 106-501. A provider will also not be reimbursed for ADHP services if the participant is receiving intensive day treatment mental health rehabilitation services during a twenty-four (24) period that immediately precedes or follows the receipt of ADHP services, to ensure that the participant is receiving services in the setting most appropriate to his/her clinical needs.
☐	HCBS Habilitation
☐	HCBS Respite Care
☐	Other services –please add boxes as needed
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)