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State/Territory Name: District of Columbia

State Plan Amendment (SPA) #: 21-0011

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

May 23, 2022

Melisa Byrd , Medicaid Director
Department of Health Care Finance
441 4th Street, N.W., 9th floor, South
Washington, D.C. 20001

Re: Supported Employment Services DC 21-0011 SES SPA

Dear Director Byrd:

The Centers for Medicare & Medicaid Services (CMS) is approving the District's request to amend its state plan to add a new 1915(i) home and community-based services (HCBS) benefit, transmittal number 21-0011. The effective date for this 1915(i) benefit is July 1, 2022. Enclosed is a copy of the approved state plan amendment (SPA).

Since the District has elected to target the population who can receive these §1915(i) State Plan HCBS, CMS approves this SPA for a five-year period expiring June 31, 2027, in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) State Plan HCBS benefit for an additional five-year period, the District must submit a renewal application to CMS at least 180 days prior to the end of the approval period. CMS' approval of a renewal request is contingent upon state adherence to federal requirements and the District meeting its objectives with respect to quality improvement and beneficiary outcomes.

Per 42 CFR §441.745(a)(i), the District will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the §1915(i) State Plan HCBS in the previous year. Additionally, at least 21 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved state plan amendment. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

CMS reminds the District that the District must have an approved spending plan in order to use the money realized from section 9817 of the ARP. Approval of this action does not constitute approval of the District's spending plan.

It is important to note that CMS' approval of this new 1915(i) HCBS state plan benefit solely addresses the District's compliance with the applicable Medicaid authorities. CMS' approval does not address the District's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, § 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice

concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Chuck Steinmetz at charles.steinmetz@cms.hhs.gov or (215) 861-4169.

Sincerely,

[redacted]

George P. Failla, Jr., Director
Division of HCBS Operations & Oversight

Enclosure

cc: Daphne Hicks CMS
Patricia J. Helphenstine, CMS
Kathryn Poisal, CMS
Deanna L. Clark, CMS
Dominique Mathurin, CMS
Frankeena McGuire, CMS
Wendy Hill Petras, CMS
Gene Coffey, CMS
Susie Cummins, CMS

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: **21-0011**

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:
~~**January 1, 2022**~~ July 1, 2022

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:
Section 1915(i) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
FFY22: $310,219.77
FFY23: $431,412.29

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-i: pages ~~40-76~~; 80-112
Attachment 4.19-B, Part I: ~~Pages 34-35; and~~ pages 37-38
~~**Attachment 2.2-A: 30-31**~~

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

10. SUBJECT OF AMENDMENT:
1915(i) – Supported Employment Services for Serious Mental Illness / Substance Use Disorder

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:
D.C. Act. 22-444

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Melisa Byrd

14. TITLE
Senior Deputy Director/Medicaid Director

15. DATE SUBMITTED
6/30/21

16. RETURN TO
Melisa Byrd
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
6/30/21

18. DATE APPROVED
5/23/2022

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
7/1/22

20. SIGNATURE OF REGIO
[redacted]

21. TYPED NAME
George P. Failla Jr.,

22. TITLE
Director, Division of HCBS Operations and Oversight

23. REMARKS
Box 8: The District authorized pen and ink change on 05/17/2022

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):*

Supported Employment for Individuals with Mental Illness
Supported Employment for Individuals with Substance Use Disorder (SUD)

2. **Concurrent Operation with Other Programs.** (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

✓	**Not applicable**
O	**Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act.** 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 1915(i) State plan HCBS. 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. *Specify:*
(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 specific 1915(i) State plan HCBS furnished by these plans;
(d) how payments are made to the health plans; and
(e) whether the 1915(a) contract has been submitted or previously approved.

☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services
☐	§1915(b)(2) (central broker)	☐	§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 §1115 of the Act.** *Specify the program*:

3. 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.*	
✓	The State plan HCBS benefit is operated by *(name of agency)* Department of Behavioral Health	
	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.	

4. 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 Eligibility evaluation	☑	☑	☐	☐
3 Review of participant service plans	☑	☑	☐	☐
4 Prior authorization of State plan HCBS	☑	☑	☐	☐
5 Utilization management	☑	☑	☐	☐
6 Qualified provider enrollment	☑	☐	☐	☐
7 Execution of Medicaid provider agreement	☑	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☑	☐	☐
10 Quality assurance and quality improvement activities	☑	☑	☐	☐

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

The "Other State Operating Agency" functions in 4.1-4.5 and 4.9-4.10 are performed by the District of Columbia Department of Behavioral Health (DBH).

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

5. ☑ **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 entity 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):*

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

7. ☑ **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.

8. ☑ **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 Education 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	July 1, 2022	June 30, 2023	Individuals with Mental Illness - 500 Individuals with SUD - 80
Year 2			
Year 3			
Year 4			
Year 5			

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. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

See Attachment 2.2-A. Under authority set forth in Section 1902(r)(2) of the SSA, the District elects to disregard income above 150% FPL for individuals meeting the needs-based criteria to receive supported employment services set for under this amendment and who are otherwise eligible to receive Medicaid services in the District of Columbia.

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 section of 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, individuals who qualify as medically needy on the basis of this election receive only 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*):
	DBH

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):*

Agents responsible for performing evaluations/reevaluations for Supported Employment Services (SES) are employed by DBH and must meet the minimum qualifications, which include:

1. Consistent with District scope of practice laws and regulations, at a minimum a bachelor's degree in an academic field related to health or allied sciences from an accredited college or university and
2. At least one year of experience in behavioral health, and work under the supervision of licensed behavioral health clinicians (e.g., psychologist, clinical social worker).

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:

As part of the diagnostic assessment for the Mental Health Rehabilitation Services (MHRS) program or as part of the comprehensive assessment in the Adult Substance Use Rehabilitation Services (ASURS) program, it is determined whether a beneficiary is interested in SES. Beneficiaries who express interest in SES during the diagnostic and comprehensive assessments receive a needs-based assessment to determine eligibility. DBH staff performs the independent evaluation of an individual's eligibility for SES. This process begins , upon receipt of the referral packet, whereby DBH reviews all submitted documentation and determines whether the applicant meets eligibility for 1915(i) Supported Employment. If the individual is approved for Supported Employment, DBH initiates a formal referral to the Supported Employment provider selected by the individual. If found ineligible, DBH provides the beneficiary with a written notice that includes information regarding the beneficiary's right to request an appeal of the decision pursuant to 29 DCMR § 9508 and the timeframes for making such a request.

The reevaluation process does not differ from the initial evaluation process. The reevaluation is conducted at least once every twelve months, and as appropriate, based on changes in need.

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):*

To be eligible for 1915(i) Supported Employment Services, an individual shall meet the following needs-based HCBS eligibility criteria:

1) Be assessed to have mental health needs that require an improvement, stabilization, or prevention of deterioration in functioning (including ability to live independently without support), which result from the presence of a mental illness; **OR**

2) Be assessed to have substance use disorder needs, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the client meets at least ASAM 1.0 Level of Care, consistent with the ASAM scoring guide. Any additional information obtained from the individual or the clinician administering the assessment (this includes clinical documentation of a need for outpatient treatment) may be used when determining Level of Care. A score of ASAM 1.0 indicates that an individual requires ongoing monitoring and assistance with managing and engaging in SUD treatments.

3) **AND** have at least one (1) of the following risk factors:

   (A) Be unable to sustain gainful employment for at least ninety (90) consecutive days as related to a history of mental illness/SUD;

   (B) More than one instance of mental illness/SUD treatment in the past two (2) years; or

   (C) Be at risk for deterioration of mental illness/SUD as evidenced by one (1) or more of the following:

      (i) Persistent or chronic risk factors such as social isolation due to a lack of family or social supports, poverty, criminal justice involvement, or homelessness;

      (ii) Care for mental illness/SUD requiring multiple provider types, including behavioral health, primary care, and long-term services and supports; or

      (iii) A past psychiatric history with no significant functional improvement that can't be addressed without treatment and supports.

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):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
To be eligible for receipt of 1915(i) Supported Employment Services an individual shall meet the need-based eligibility criteria described in item 5 above.	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 standardized assessment tool utilized by the District. Nursing facility level of care is determined by a standardized assessment tool which includes an assessment of the individual's support needs across three domains including: (1) functional; (2) skilled care; and (3) cognitive/behavioral. 1. Functional – Type and frequency of assistance required with activities of daily living such as bathing, dressing, eating/feeding, transferring, mobility, and toileting. 2. Skilled Care – Occurrence and frequency of certain treatments/procedures, skilled care (e.g. wound care, infusions), medical visits, and other types of formal care. 3. Cognitive/Behavioral - Presence of and frequency with which certain conditions and	Individuals who qualify for ICF/MR services will not be assessed via DHCF's 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 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 criterial 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;	For inpatient hospital psychiatric emergency detention D.C. Code § 21-522 requires that an application for admission is accompanied by a certificate of a psychiatrist, qualified physician, or qualified psychologist on duty at the hospital or the Department of Behavioral Health that they: 1. Have determined the person has symptoms of a mental illness making them likely to injure themselves or others unless immediately detained; and 2. Have determined hospitalization or detention in a certified facility is the least restrictive form of treatment available to prevent the person from injuring themself or others

	behaviors occur (e.g., communications impairments, hallucinations or delusions, physical/verbal behavioral symptoms, eloping or wandering).	4. Behavior problems; 5. Autism; 6. Cerebral Palsy; 7. Epilepsy; or 8. Spina Bifida. c. The person's primary disability is 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 TermCare/Chronic Care Hospital

**LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 180 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) and 42 CFR 441.745(a)(2)(vi)(A). (*Specify target group(s)*):

Individuals enrolled in the 1915(i) SES program shall be:

1. 18 years of age and older, and
2. Have a documented diagnosis of Mental Illness and/or Substance Use Disorders.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box 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. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) 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 person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: 1	
ii.	**Frequency of services**. The state requires (select one):	
	⊙	**The provision of 1915(i) 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 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

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

1. ☑ **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 home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) 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 home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The District assures that all waiver settings/providers authorized in this submission comply with federal Home and Community-Based Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. 1915(i) Supported Employment services are provided in the Supported Employment provider's service site (typically the provider's office), the individual's home, employment site, or other locations in the community. When services are provided in a home setting it is often because the individual is employed an unable to travel to the providers office, and services typically consist of assessing progress, discussing goals, and ensuring current employment is a good fit. Individuals receiving Supported Employment services live in homes of their own choosing, which are a part of the community at large. This may include individual/single occupancy dwellings, residences which support multiple individuals such as mental health community residential facilities or family homes where multiple family members receive services, or with families or friends in the same manner as any adult who does not have a mental illness or substance use disorder. This waiver does not include settings that are presumed to have institutional qualities. All settings have been determined to meet the settings requirements. These home and community-based settings are:

- Integrated in and support full access 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 as individuals not receiving Medicaid HCBS;
- Selected by the individual from among setting options, including non-disability specific settings;
- Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimize, but do not regiment, individual initiative, autonomy and independence in making life choices; including but not limited to, daily activities, physical environment, and with whom to interact; and
- Facilitate choice regarding who provides Supported Employment services.

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 need for HCBS. *(Specify qualifications):*

DBH conducts face-to-face assessments to determine an individual's support needs for SES. The face-to-face needs-based assessment for Mental Health Supported Employment must be completed by one of the following practitioner types licensed or otherwise authorized to practice pursuant to qualifications prescribed by DBH and the District of Columbia Department of Health (DOH): Psychiatrist; Psychologist; Licensed Independent Clinical Social Worker (LICSW); Licensed Practical Counselor (LPC); Licensed Marriage and Family Therapist (LMFT); Advanced Practice Registered Nurse (APRN); Registered Nurse (RN); Licensed Independent Social Worker (LISW); Psychology Associate; Licensed Graduate Professional Counselors (LGPC); Licensed Graduate Social Worker (LGSW); Physician Assistant; or Credentialed staff under the supervision of a behavioral health clinician permitted to diagnose mental illness.

The face-to-face needs-based assessment for SUD Supported Employment must be completed by one of the following practitioner types licensed or otherwise authorized to practice pursuant to qualifications prescribed by DBH and the DOH: Physician; Psychologist; LICSW; LPC; LMFT; APRN; LISW; LGPC; LGSW; RN; Physician Assistant; or Certified Addiction Counselor I or II.

These practitioners have training in the assessment of individuals with behavioral health conditions that trigger a potential for HCBS services and supports. DBH is not a provider of 1915(i) Supported Employment services.

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

DBH is responsible for development of person-centered service plans (PCSPs). The PCSP for Mental Health SES must be developed by one of the following practitioner types licensed or otherwise authorized to practice pursuant to qualifications prescribed by DBH and the District of Columbia Department of Health (DOH): Psychiatrist; Psychologist; LICSW; LPC; LMFT; APRN; RN; LISW; Psychology Associate; LGPC; LGSW; Physician Assistant; or Credentialed staff under the supervision of a behavioral health clinician permitted to diagnose mental illness.

The PCSP for SUD SES must be developed by one of the following practitioner types licensed or otherwise authorized to practice pursuant to qualifications prescribed by DBH and the DOH: Physician; Psychologist; LICSW; LPC; LMFT; APRN; LISW; LGPC; LGSW; RN; Physician Assistant; or Certified Addiction Counselor I or II.

6. **Supporting the Participant in Development of Person-Centered Service Plan**. 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 person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

As soon as practicable, after an eligibility determination, the qualified DBH staff person will complete a face-to-face assessment with the individual and review supporting documentation to develop a person-centered service plan (PCSP) that includes facilitating the client's choice of service provider.

DBH conducts an assessment for Supported Employment services and informs the individual about their choices in Supported Employment providers and documents the individual's selection along with their signature. A referral packet containing the assessment results, the proposed PCSP, and Supported Employment provider selection is sent to the Supported Employment Provider. DBH is not a 1915(i) Supported Employment Provider.

Consistent with federal guidelines regarding individual direction as part of the PCSP development process, the individuals developing the proposed PCSPs abide by DBH-issued practice guidelines on conducting person-centered assessments and planning. Those guidelines align with the federal guidelines and stress the that the plan must reflect the services and supports that are important to the individual to meet the needs identified through an assessment. The staff person completing the PCSP actively partners with the individual and, if applicable per the individual's request, their natural supports (e.g. family members, friends) in all planning meetings and/or case conferences regarding the individual's recovery and services and supports. The resulting plan reflects the individual's personally defined goals, and objectives and interventions derived from a collaborative process to ensure delivery of services in a manner that reflects personal preferences and choices. It also details the scope, duration, and frequency of services. Interpretation services are made available when needed to ensure that the individual receives information in their language of choice. Additionally, persons with disabilities are provided with alternative formats and other assistance to ensure equal access. Individuals can request updates to the plan as needed.

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 person-centered service plan):*

All consumers receiving Supported Employment have free choice of providers. DBH informs participants of all available Supported Employment providers and how to access them. Based on this information, participants complete and sign a document which identifies their choice of

Supported Employment provider. This form is submitted with the needs-based assessment and PCSP to DBH who conducts the evaluation for eligibility determination.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

The SMA's designee, DBH, will review each PCSP as part of their administrative authority. Once the DBH staff person develops the PCSP, the services plan will be reviewed by the staff person's supervisor, or another individual identified by DBH. Following approval, the SMA creates a service authorization.

9. **Maintenance of Person-Centered 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 §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:	Supported Employment

Service Definition (Scope):

Supported Employment is an evidence-based practice adopted by DBH that:

a) Provides ongoing work-based vocational assessment, job development, job coaching, treatment team coordination, and vocational and therapeutic follow-along supports;
b) Involves community-based employment consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual;
c) Provides services at various work sites; and
d) Provides part-time and full-time job options that are diverse, competitive, integrated with co-workers without disabilities; are based in business or employment settings that have permanent status rather than temporary or time-limited status; and that pay at least the minimum wage of the jurisdiction in which the job is located.

The following services are provided to individuals:

a) Vocational Supported Employment services:
   1) Intake;
   2) Vocational Assessment;
   4) Individualized Work Plan (IWP) Development, in which the individual's preferences drive the employment and career planning process. The IWP includes an employment goal and the support services required to reach the goal, such as strategies to address stressor situations and assistance with symptom self-monitoring and self-management. The plan development is conducted using the person-centered planning process;
   5) Disclosure Counseling;

6) Treatment Team Coordination;
7) Job Development;
8) Job Coaching; and
9) Vocational Follow-Along Supports, which are provided to the individual or employer to help the individual maintain employment including through review of job performance and problem-solving; and

(b) Therapeutic Supported Employment services:
1) Therapeutic Follow-Along Supports, which are interventions related to addressing behavioral health symptoms, and which include: crisis intervention, symptom management, behavior management, and coping skills needed to improve the individual's ability to maintain employment; and
2) Benefits Counseling, which helps individuals understand how employment may impact benefits and which may also involve advocacy on behalf of the person to resolve issues.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose 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):*
Mental Health Supported Employment (SE) Provider	N/A	Supported Employment (SE) Providers are certified by DBH. To be eligible to apply for certification, providers must: 1) first be certified by DBH as a Mental Health provider 2) submit proof of adequate staffing for the delivery of SE services in accordance to DBH regulations, and 3) submit proof of a Supported Employment Policy that enumerates the provider's policies and procedures for delivering services in accordance with DBH regulations.	N/A

		The District's regulations governing SE providers lay out requirements related to: fidelity assessments, staffing qualifications and ratios, supervision, service documentation, coordination with an individual's treatment provider, required service components, and reimbursement.	

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):*
Supported Employment Provider	DBH	Upon certification, 1 year after initial certification, and subsequently every 2 years as a part of recertification

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

☐	Participant-directed	☑	Provider managed

2. ☐ **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):*

N/A. SE services are not rendered by relatives, legally responsible individuals, or legal guardians.

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.
○	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.
○	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):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	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)* :

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. 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):*

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). *(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 that does not result in payment for medical assistance to the individual). *(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 the method for calculating the dollar values in the budget based on reliable costs and service utilization, 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 person-centered service plan.):*
	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

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

2. **Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**

3. **Providers meet required qualifications.**

4. **Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**

5. **The SMA retains authority and responsibility for program operations and oversight.**

6. **The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**

7. **The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints and incidents of unexpected death.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	**1a) Service plans address assessed needs of 1915(i) participants**
Discovery	
Discovery Evidence *(Performance Measure)*	Medicaid enrollees receiving Supported Employment services who have a service plan that addresses his/her assessed needs and personal goals Numerator: Number of reviewed service plans for Medicaid enrollees that address assessed needs and personal goals Denominator: Number of service plans for Medicaid enrollees reviewed
Discovery Activity	Data Source: DBH review of service plans Sample: 100% (Universe reviewed at the time of enrollment and re-evaluation)

(Source of Data & sample size)	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DBH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DBH
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	**1b) Service plans are updated annually**
Discovery	
Discovery Evidence *(Performance Measure)*	Service plans updated at least annually Numerator: Number of Medicaid enrollees with service plans updated at least annually Denominator: Number of Medicaid enrollees receiving Medicaid SE services
Discovery Activity *(Source of Data & sample size)*	Data Source: DBH review of service plans and Medicaid claims data from MMIS Sample: 100% (Universe reviewed at the time of enrollment and re-evaluation)
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DBH
Frequency	Annually
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DBH
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	**1c) Service plans document choice of services and providers**
Discovery	
Discovery Evidence *(Performance Measure)*	Service Plans document choice of services and providers Numerator: Number of Medicaid enrollees receiving SE services whose records have a signed choice of provider form Denominator: Number of Medicaid enrollees receiving SE services (evidenced by at least one paid Medicaid claim for SE services)
Discovery Activity *(Source of Data & sample size)*	Data Source: DBH review of Choice of Provider form and Medicaid claims data from MMIS Sample: 100% (Universe reviewed)
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DBH
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DBH
Frequency	Quarterly

(of Analysis and Aggregation)	

Requirement	**2a) An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future**
Discovery	
Discovery Evidence *(Performance Measure)*	Individuals potentially eligible to receive Medicaid SE services are screened for interest Numerator: Number of Medicaid enrollees (age 18-64) in sample that were screened for SE interest as a part of the Diagnostic Assessment service in the Mental Health Rehabilitation Services (MHRS) program or as a part of the Comprehensive Assessment in the Adult Substance Use Rehabilitative Services (ASURS) program by providers required to screen for SE Denominator: Number of Medicaid enrollees (age 18-64) in sample that had Diagnostic Assessment (MHRS)/Comprehensive Assessment (ASURS) service with MHRS/ASURS providers who are required to screen for SE
Discovery Activity *(Source of Data & sample size)*	Data Source: DBH MHRS/ASURS data and Medicaid claims data from MMIS Sample: Using RAT-STATS, we will select a statistically valid random sample of cases from the Medicaid universe to conduct chart review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DBH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DBH
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	**2b) The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately**
Discovery	
Discovery Evidence *(Performance Measure)*	Medicaid enrollees who expressed interest in SE as a part of a Diagnostic Assessment (MHRS) or Comprehensive Assessment (ASURS) service receive a needs-based assessment to determine eligibility Numerator: Number of Medicaid enrollees in sample that received a functional assessment Denominator: Number of Medicaid enrollees (age 18-64) in sample who indicated interest in SE (as evidenced by documentation in assessment or treatment plan), as part of a Diagnostic Assessment or Comprehensive Assessment service by a provider required to screen for SE (Numerator of Measure 2a)
Discovery Activity *(Source of Data & sample size)*	Data Source: DBH MHRS/ASURS data and Medicaid claims data from MMIS Sample: Using RAT-STATS, we will select a statistically valid random sample of cases from the Medicaid universe to conduct chart review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DBH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DBH
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	**2c) The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS**
Discovery	
Discovery Evidence	The 1915(i)-benefit eligibility of enrolled individuals is reevaluated at least every 365 days.

(Performance Measure)	Numerator: Number of Medicaid beneficiaries enrolled in SE that received a reassessment at least every 365 days Denominator: Number of Medicaid beneficiaries enrolled in SE services
Discovery Activity *(Source of Data & sample size)*	Data Source: DBH electronic records system Sample: 100% (Universe reviewed)
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DBH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DBH
Frequency *(of Analysis and Aggregation)*	Quarterly.

Requirement	**3) Providers meet required qualifications**
Discovery	
Discovery Evidence *(Performance Measure)*	**Performance Measure 1** Percent of Medicaid SE provider agencies that meet DBH certification requirements Numerator: Number of Medicaid SE provider agencies who have active certification Denominator: Number of Medicaid SE provider agencies providing SE services (evidenced by paid Medicaid claim for SE service)
Discovery Activity *(Source of Data & sample size)*	Data Source: DBH Certification data and Medicaid claims data from MMIS Sample: 100% (Universe reviewed)
Monitoring	DBH

Responsibilities *(Agency or entity that conducts discovery activities)*	
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DBH
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	**3) Providers meet required qualifications**
Discovery	
Discovery Evidence *(Performance Measure)*	**Performance Measure 2** Provider agencies' Supported Employment Managers meet DBH's mandatory SE training requirements Numerator: Number of Supported Employment Managers that meet DBH's mandatory training requirements for Supported Employment Denominator: Number of Supported Employment Managers employed by DBH-certified providers
Discovery Activity *(Source of Data & sample size)*	Data Source: DBH Supported Employment Program data Sample: 100% (Universe reviewed)
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DBH
Frequency	Annually
Remediation	
Remediation Responsibilities	DBH

(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	**4) Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2)**
Discovery	
Discovery Evidence *(Performance Measure)*	Providers focus on providing opportunities for employment and work in competitive integrated settings to individuals receiving Medicaid HCBS Numerator: Number of SE Employment Specialists that provide competitive job options to Medicaid enrollees receiving SE services about 85% of the time or more (competitive jobs are of a permanent status rather than temporary or time-limited status, are not set aside for individuals with disabilities, and pay at least minimum wage) Denominator: Number of SE Employment Specialists at all Medicaid SE providers
Discovery Activity *(Source of Data & sample size)*	Data Source: DBH SE Program fidelity reviews Sample: 100% (Universe reviewed)
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DBH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DBH
Frequency	Quarterly

(of Analysis and Aggregation)	

Requirement	**5) The SMA retains authority and responsibility for program operations and oversight**
Discovery	
Discovery Evidence *(Performance Measure)*	SE provider records contain completed Medicaid Provider agreements Numerator: Number of SE provider records containing completed Medicaid Provider agreements Denominator: Number of SE provider records reviewed
Discovery Activity *(Source of Data & sample size)*	Data Source: Provider Data Management System (PDMS) Sample: 100% (Universe reviewed)
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DHCF
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DHCF
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	**6) The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
Discovery	
Discovery Evidence	**Performance Measure 1** Medicaid SE claims pass audit standards

(Performance Measure)	Numerator: Number of Medicaid SE audited claims that pass audit standards Denominator: Number of Medicaid SE claims selected for auditing
Discovery Activity *(Source of Data & sample size)*	Data Source: Medicaid claims data from MMIS Sample: 100% of SE claims selected for auditing
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DBH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DBH
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	**6) The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
Discovery	
Discovery Evidence *(Performance Measure)*	**Performance Measure 2** Medicaid SE claims are paid using the correct rate established by DHCF under fee schedule Numerator: Number of Medicaid SE audited claims that were paid the correct rate Denominator: Number of Medicaid SE claims selected for auditing
Discovery Activity *(Source of Data & sample size)*	Data Source: Medicaid claims data from MMIS Sample: 100% of SE claims selected for auditing

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DBH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DBH
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	**7) The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints and incidents of unexpected death**
Discovery	
Discovery Evidence *(Performance Measure)*	**Performance Measure 1** Unexplained deaths and incidents related to abuse, neglect, exploitation, and use of restraints involving Medicaid SE providers are reported within 24 hours or the next business day Numerator: Number of incidents involving Medicaid SE providers reported within 24 hours or next business day Denominator: Number of unexplained deaths and incidents related to abuse, neglect, exploitation, and use of restraints involving Medicaid SE providers
Discovery Activity *(Source of Data & sample size)*	Data Source: Major Unusual Incident (MUI) Reports Sample: 100% (Universe reviewed)
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DBH

Frequency	Monthly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DBH
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	**7) The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints**
Discovery	
Discovery Evidence *(Performance Measure)*	**Performance Measure 2** Allegations of abuse, neglect, exploitation, and use of restraints involving Medicaid SE providers are investigated by DBH Numerator: Number of incidents investigated by DBH that are related to allegations of abuse, neglect, exploitation, and use of restraints and involve Medicaid SE providers Denominator: Number of incidents related to allegation of abuse, neglect, exploitation, and use of restraints involving Medicaid SE providers
Discovery Activity *(Source of Data & sample size)*	Data Source: MUI Reports Sample: 100% (Universe reviewed)
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DBH
Frequency	Monthly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation*	DBH

	activities; required timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Quarterly

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

The Supported Employment providers will be required to operate their programs based on established regulations and Supported Employment Evidence Based Practice (EBP) protocols and establish and maintain a comprehensive quality assurance program, for the purpose of evaluating program strengths and needs. Program strengths and needs will be identified through the ongoing collection and analysis of data, and remediation activities.

DBH will conduct site visits, review documents, and interview staff and individuals, to verify the effectiveness of systems the provider has in place and fidelity to the EBP. DBH will notify providers of any actual or potential individual or systems problems and provide technical assistance. The provider will analyze DBH's findings to develop and submit proposed corrective actions. DBH will then examine the outcomes of corrective actions to measure the effectiveness of the providers' corrective action and the need to prioritize areas in need of improvement. DBH will ensure that providers are implementing continuous quality improvement strategies to prevent recurrence of findings.

2. Roles and Responsibilities

DBH will conduct reviews based on fidelity to the EBP and the measures contained in the 1915(i) Quality Improvement (QI) Strategy. DBH will meet regularly with providers to discuss and evaluate progress, share results of data collection activities, and provide technical assistance and guidance as needed.

The Supported Employment providers will structure their programs and provide services to align with the established regulations, meet regularly with DBH, participate in program reviews and QI analysis activities, conduct internal QI activities and share any challenges and barriers with DBH.

3. Frequency

DBH will meet with providers regularly. Fidelity reviews and other QI activities will be scheduled continuously throughout the year to accommodate scheduling of all providers and gathering all the necessary data to evaluate the programs.

4. Method for Evaluating Effectiveness of System Changes

As part of the QI Strategy, DBH proposes to work collaboratively with providers to examine systems, identify issues, evaluate factors impacting the delivery of services, design corrective actions, and measure the success of system improvement. DBH has primary day to day responsibility for assuring that there is an effective and efficient quality management system is in place. DBH 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 all providers will be evaluated for fidelity to the evidence-based Supported Employment model, in addition to the QI Strategy measures. Results of this evaluation process may demonstrate a need to change performance indicators, including changing priorities; using different approaches to ensure progress; and 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 a timeframe identified by DBH. 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-to-face meetings, by email, or through DBH 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 Supported Employment
	Supported Employment services are reimbursed according to a DHCF fee schedule rate and on a fifteen (15)-minute unit basis. DHCF's fee schedule rate is set as of January 1, 2022 and is effective for services provided on or after that date. All rates are published on the agency's website at www.dc-medicaid.com/dcwebportal/home. Rates are consistent with efficiency, economy, and quality of care. The fee development methodology is primarily composed of provider cost modeling, through DC provider compensation studies and cost data. Fees from similar State Medicaid programs may also be considered. The following list outlines the major components of the cost model used in developing the fee schedule: 1. Staffing Direct Wages, including but not limited to: salaries, fringe benefits (e.g., health and dental insurance, Medicare tax, employment tax), and contract costs for eligible direct care service providers; 2. Direct Program Costs, including but not limited to: materials; supplies; staff travel and training costs; program, clinical, and support salary and benefit costs; and additional allocable direct service costs unique to a provider; 3. Indirect Costs, including but not limited to: administrative and management personnel costs, occupancy costs, security costs, and maintenance and repair costs; 4. Service utilization statistics, including but not limited to: the total units of service provided and data related to service volume; 5. Productivity Factors, including but not limited to hours of service; and 6. Unique Program Costs.
☐	HCBS Habilitation
☐	HCBS Respite Care

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)
☐	Other Services (specify below)	