State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

February 14, 2013

Gloria Nagle, PhD, MPA
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services, Region IX
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

STATE PLAN AMENDMENT 09-023

Dear Ms. Nagle:

The California Department of Health Care Services (DHCS) is formally resubmitting responses to your March 26, 2010, letter transmitting the Centers for Medicare & Medicaid Services' (CMS') Request for Additional Information (RAI) concerning the DHCS State Plan Amendment (SPA) 09-023. DHCS has been working closely with CMS representatives in both the regional and central offices and has revised the attached amendment pages as requested. Please find the following enclosures in response to the RAI:

- Formal response to CMS' RAI with associated attachments
- Revised 1915(i) State Plan Amendment, Attachment 3.1-C
- Revised State Plan pages for reimbursement, Attachment 4.19-B pages 69-77

Additionally, as suggested by CMS, DHCS is requesting to split SPA 09-023 into two SPAs: SPA 09-023A, which includes the attachments submitted with this letter; and SPA 09-023B which will be sent under separate cover and include an additional reimbursement methodology for one of the services included in SPA 09-023A. This split will allow CMS to approve 09-023A while DHCS addresses CMS' remaining questions regarding the reimbursement methodology in SPA 09-023B.

Director's Office
1501 Capitol Avenue, MS 0000, P.O. Box 997413, Sacramento, CA 95899-7413
(916) 440-7400 phone, (916) 440-7404 fax
Internet Address: www.dhcs.ca.gov

FEB 13 2013

We appreciate CMS' assistance and guidance through this process. If you have any questions, please contact Mr. John Shen, Chief, Long-Term Care Division, at (916) 552-9105 or by email at John.Shen@dhcs.ca.gov .

Sincerely,

Toby Douglas
Director

Enclosures

cc: Ms. Cynthia Nanes
U.S. Department of Health and human Services
Centers for Medicare and Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94109-6706

Ms. Beverly Binkier
U.S. Department of Health and human Services
Centers for Medicare and Medicaid Services
90 Seventh Street, Suite 5-300
San Francisco, CA 94109-6706

Ms. Kathy Poisal
U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Ms. Michelle MacKenzie
U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Mr. John Shen, Chief
Long-Term Care Division
Department of Health Care Services
1501 Capitol Avenue, MS 0018
Sacramento, CA 95899-7417

Mr. Jim Knight, Assistant Deputy Director
Community Operations Division
Department of Developmental Services
1600 Ninth Street, Room 320, MS 3-9
Sacramento, CA 95814

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 09-023B

2. STATE: CALIFORNIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: OCTOBER 1, 2009

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:
SOCIAL SECURITY ACT SECTION 1915(i)

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 -- $ 4.6 Million
b. FFY 2011 -- $ 5.9 Million
c. FFY 2012 -- $ 6.4 Million
d. FFY 2013 -- $ 6.6 Million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
TO BE DETERMINED AFTER APPROVAL OF SPA 09-023A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
TO BE DETERMINED AFTER APPROVAL OF SPA 09-023A

10. SUBJECT OF AMENDMENT:

1915(i) HCBS-- MEDIAN RATE REIMBURSEMENT FOR COMMUNITY LIVING ARRANGEMENTS IN LICENSED SETTINGS

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:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED
February 14, 2013

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.3.26
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **09-023A**

2. STATE: CALIFORNIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
OCTOBER 1, 2009

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:
SOCIAL SECURITY ACT 1915(I)

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 – $168.5M c. FFY 2012 – $137.2M
b. FFY 2011 – $149.2M d. FFY 2013 – $140.6M

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

ATTACHMENT 3.1-c pages 1-~~63~~ 103
ATTACHMENT 4.19-B pages ~~64-75~~ 69-77

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

NONE

10. SUBJECT OF AMENDMENT:
1915(i) – HOME AND COMMUNITY-BASED SERVICES

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:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED: 12/30/09 (original), 9/30/10 (amended)

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.3.26
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

* PEN & INK CHANGE REQUEST

FORM HCFA-179 (07-92)

DEPARTMENT OF DEVELOPMENTAL SERVICES
SUMMARY OF BUDGET REDUCTIONS
JULY 2009

INTRODUCTION

The State of California is experiencing an unprecedented budget shortfall largely due to the severe national economic crisis. Every area of state government is impacted by this fiscal crisis, including the Department of Developmental Services (DDS or Department).

In February, the Governor and Legislature reached agreement on a budget solution to address a $42 billion budget deficit and restore California's fiscal balance. Unfortunately, since that time the global recession has deepened and the State now faces an additional deficit exceeding $26 billion.

The Department has undertaken numerous efforts to control costs throughout our entire system, including staffing reductions in the DDS headquarters and state-operated developmental centers, contract suspensions, furloughs of state employees with a corresponding 14.2 percent decrease in salary, and development of proposals to reduce regional center operations and purchase of services. Throughout this difficult process, the Department has remained committed to preserving the entitlement to services and supports and the continued implementation of the individualized planning process mandated in the Lanterman Developmental Disabilities Services Act (Lanterman Act) and Early Intervention Services Act (Early Start).

The Department recognizes that the State's worsening fiscal situation and the specific savings proposals pending legislative actions have created uncertainty and concern. This briefing paper was prepared to provide an accurate and complete overview of the Department's efforts to manage our limited resources.

OVERVIEW

DDS is responsible under the Lanterman Act for ensuring that more than 240,000 people with developmental disabilities receive the services and supports needed to live independent and productive lives. These disabilities include mental retardation, cerebral palsy, epilepsy, autism and related conditions. Services are delivered directly through four state-operated developmental centers and two community facilities, and under contract with a statewide network of 21 nonprofit regional centers.

In the 2008-09 Fiscal Year (July 1, 2008 to June 30, 2009), $4.7 billion was allocated to DDS to provide these services. Due to caseload increases and higher service needs, the 2009-10 budget was projected to grow by over $345 million. The Department's budget has two sources of revenue: state dollars, called General Fund, and monies from the federal government. The State receives a small federal grant for the Early

Start Program serving infants and toddlers from birth to three years of age and matching funds for services provided to approximately 154,000 consumers enrolled in the federal Medicaid Program (Medi-Cal). The Department operates a large (both in terms of enrollment numbers and breadth of covered services) federally approved Home and Community-based Services Waiver (Waiver) for regional center consumers who are Medi-Cal beneficiaries. Through this Waiver the federal government participates in the funding of community services to eligible consumers. The number of regional center consumers enrolled on the Waiver has grown to 80,862 and the Department estimates approximately 3,700 new regional center consumers will be added to the Waiver this fiscal year. The Department is currently unable to receive federal matching funds for community services delivered to consumers who are on Medi-Cal but not eligible for the Waiver. To be eligible, a consumer cannot reside in a licensed health care facility and must meet the level-of-care criteria for Waiver enrollment.

In January 2009, the Governor's Budget proposed a 3 percent payment reduction for regional centers and service providers and called for the Department to work with stakeholders to achieve a $334 million General Fund savings. The Legislature adopted the 3 percent proposal, reduced the Department's budget by $100 million (General Fund) and required the Department to work with stakeholders and submit a plan explaining how the savings would be achieved. In order to make sure the savings would occur, the Legislature adopted language to require an additional provider payment reduction of 7.1 percent if a savings plan for the $100 million was not adopted by the Legislature prior to September 1, 2009.

In February, the Department implemented a stakeholder process to meet the legislative requirements. Three stakeholder public forums were held in Sacramento, Oakland, and Los Angeles. A workgroup was established to discuss potential budget proposals with representatives from statewide stakeholder groups (list of participants enclosed) impacted by the reductions. Legislative staff was invited to participate in all the meetings. In addition, the California Disability Community Action Network hosted a telephone town hall meeting for DDS to allow an additional opportunity for input from the community. All stakeholders were encouraged to submit ideas and comments in writing to the Department. The Department distributed public hearing meeting information to hundreds of stakeholder contacts, posted information on the department internet site, and made efforts to ensure that the meetings and materials met the public's accessibility and language needs.

In total, approximately 1,400 stakeholders attended the three public forums, including those stakeholders who attended by conference call. The Department received approximately 1,350 written recommendations outlining budget suggestions and several phone calls from stakeholders. Department staff consolidated all recommendations received, as well as those outlined in the DDS Cost Containment report submitted to the Legislature in December 2007, and presented this information to the workgroup in its deliberation of proposals that would achieve the targeted $100 million reduction.

The workgroup met for 25 hours to review and prioritize the proposals. While not every member supported each proposal, the final package represents recommendations informed by the workgroup to achieve the targeted savings while maintaining the entitlement and ensuring program and service integrity.

Unfortunately, the economy worsened and additional budget reductions were contained in the Governor's May Budget Proposal (May Revise). After release of the May Revise, the Department reconvened the stakeholder workgroup to review and prioritize an additional $234 million in reductions. Unlike the prior $100 million budget reduction, savings for the new $234 million could come from the entire developmental services system, including developmental centers. The workgroup divided into subcommittees to address and refine proposals by program area, and subsequently reconvened as a full workgroup to consider and prioritize each proposal. While members do not support the $234 million budget cut, the final package reflects the input of the workgroup to achieve the targeted savings while maintaining the entitlement, protecting the individual planning process.

Following completion of the budget proposals by DDS, the Assembly and Senate Budget Committees considered the proposals during public hearings. Subsequently, the Joint Legislative Conference Committee on the budget adopted the Department's recommendations and associated trailer bill language. These changes are pending final legislative approval and enactment as part of the overall state budget negotiations.

PROPOSALS TO ACHIEVE TARGETED SAVINGS

The Department developed and submitted to the Legislature two sets of savings proposals. The first set of proposals was submitted in April 2009 to achieve a General Fund savings target of $100 million. The second set of proposals was submitted in June 2009 to achieve an additional General Fund savings of $234 million. The following summary consolidates all of the proposals into a comprehensive list totaling $334 million in General Fund savings. The amount noted for each proposal represents the associated General Fund savings in Fiscal Year 2009-10.

These proposals do not change the Individualized Family Services Plan/Individual Program Plan processes, nor do they change existing appeal rights and processes.

A. Expanded Federal Funding (New funds anticipated $78.8 million)

The Department will work with the California Department of Health Care Services, the federal Centers for Medicare and Medicaid Services and stakeholders to maximize federal funding received by California, as follows:

1. An amendment, called a 1915(i), to California's Medicaid plan will be pursued to allow receipt of federal funding for services to consumers who are on Medi-Cal but not eligible for the Waiver.

2. Services, such as day care, will be added to the existing Waiver.

3. The Department will pursue becoming an Organized Health Care Delivery System to ensure California receives federal funds already assumed in the budget of $44 million and achieve an additional $4.6 million in savings.

4. Regional centers will not newly vendor any licensed community care facilities (CCF) with a capacity of 16 or more beds which do not qualify for federal Medicaid funds because of their institutional setting. Effective July 1, 2012, regional centers will not be able to purchase services from existing facilities, as described above, unless the facility has a written agreement and plan to qualify for Medicaid funding through downsizing or becoming more 'homelike' by June 30, 2013.

B. Developmental Centers ($27.2 million)

In addition to the employee furloughs and staff reductions noted above, the Department will implement the following proposals associated with the state operated Developmental Centers (4 facilities) and Community Facilities (2 facilities):

1. The Department will close the Sierra Vista Community Facility. Residents will relocate to living options based upon their needs and choices as identified in their Individual Program Plans.

2. Several capital outlay projects (facility repairs) will be delayed to achieve one-time savings in the 2009-10.

3. Up to 30 existing residents in the secure treatment program at Porterville Developmental Center will enter a specialized transition treatment area where their services will be eligible for federal matching funds.

C. General Standards ($45.9 million)

This proposal establishes the following standards to be used by regional centers in authorizing services:

1. Regional centers shall not purchase experimental treatments, therapeutic services or devices that have not been clinically determined or scientifically proven to be effective or safe or for which risks and complications are unknown.

2. The Lanterman Act currently requires regional centers to use generic services when available. If a consumer or family chooses not to access available generic services (e.g. IHSS, Medi-Cal, public school, California Children's Service), regional centers will not be able to pay for the service.

3. The Lanterman Act currently requires regional centers to use generic services when available. Medical and dental services covered by generic resources, such as Medi-Cal, health plan(s) or private insurance, will not be purchased by the regional centers for consumers enrolled in these insurance plans without proof of denial from the insurance provider. This proposal applies to consumers three

years of age or older. Services can be provided pending approval, initiation or denial of the service.

4. Services identified in the Individualized Family Services Plan/Individual Program Plan that can be provided by more than one vendor and still meet the consumer's needs will be compared and regional centers will purchase the services from the least costly service provider that can meet the consumer's needs. In determining the least costly provider, the cost of transportation and the availability of federal financial participation will be considered. The consumer will not be required to use the least costly provider if it will result in the consumer moving to more restrictive or less integrated services or supports.

5. Regional centers will provide information to the consumer or his or her authorized representative about the type and costs of services provided each year to the consumer.

D. Transportation Reform ($16.9 million)

Regional centers ensure the transportation needs of consumers identified in their Individualized Family Services Plan/Individual Program Plan are met. The centers may obtain these services from various public and private transportation providers when the transportation needs cannot be met by family members. This proposal will require regional centers to pursue lower cost transportation services that can meet the consumers' individual needs, as follows:

1. If a consumer can use public transportation, they will be assisted to do so, rather than purchase special transportation.

2. While still meeting the consumer's need, the least expensive transportation option will be used.

3. Regional centers will buy services close to consumers' homes to save on transportation costs, when such services meet the individual's needs.

4. If feasible, families will provide transportation for children as opposed to it being purchased by regional centers.

E. Uniform Holiday Schedule ($16.3 million)

Most day programs, look-alike day programs and work activity programs recognize 10 holidays, but these holidays may differ between programs. This proposal standardizes the holiday schedule for these programs and increases the total number to 14 days. Programs will have the same 14 holidays off each year. The statute authorizes the Department to adjust the proposed list of holidays with sufficient notice. In addition to the savings from the decreased number of program days, savings from the reduced transportation costs will be realized.

F. New Service for Seniors at Reduced Rates ($1.0 million)

Most day programs, look alike day programs and work activity programs do not have programs specifically for aging consumers who might want a different program model designed to meet their needs. This proposal requires all of these types of programs to offer a senior component to their current program design. About 5% of consumers over 50 years of age are expected to choose this new service option.

G. Custom Endeavors Option ($12.7 million)

Employment for persons with developmental disabilities remains a high priority for the Department. This proposal expands options for consumers to gain employment, work experience through volunteerism, and/or start their own business. Day programs, look alike day programs and work activity programs will offer this new service model as a component of their current program design. This option will be provided to consumers consistent with their Individual Program Plan.

H. In-Home Supportive Services (IHSS) ($1.3 million)

Under the Lanterman Act, regional centers are required to use available generic resources such as IHSS. This proposal requires supported living providers to help consumers get IHSS within five days of moving into supported living. While the consumer is waiting for IHSS services, the supported living provider will be paid the IHSS rate for IHSS type services provided to the consumer. This does not change the Individual Program Plan or services to the consumers.

I. Supported Living Services ($6.9 million)

Consumers who live in the community can receive services necessary to remain in their own home. These services are available from a Supported Living Services (SLS) provider. This proposal provides specific direction on the provision of these services, as follows:

1. Regional centers will work with SLS providers on rates of payment that are cost effective, include reasonable administrative costs, and can be no higher than the rate on July 1, 2008.

2. Unless needed to implement a consumer's Individual Program Plan in limited and unique circumstances, regional centers will not be allowed to pay a consumer's rent.

3. As long as it meets the consumer's needs, regional centers will attempt to have consumers who share a home use the same SLS provider.

J. Utilization of Neighborhood Preschools ($8.9 million)

Some toddlers served by the regional centers currently attend segregated infant development programs. This proposal supports a different service delivery model whereby families, through the Individualized Family Services Plan/Individual Program Plan, will be able to have their toddler attend local preschools with the regional center also providing necessary supports.

K. Group Training for Parents on Behavior Intervention Techniques ($6.4 million)

At the time of development, review or modification of the Individualized Family Services Plan/Individual Program Plan, the regional centers will be required to consider providing group training to parents in lieu of providing some or all of the in-home parent training component of the behavior intervention services. Similar programs have been found to be successful and cost effective because parents who attend group training on behavioral interventions can better support their children.

L. Behavioral Services ($19.3 million)

This proposal establishes the following specific standards to be used by regional centers in purchasing behavioral services:

1. Consistent with the need established in the consumer's Individualized Family Services Plan/Individual Program Plan, regional centers can purchase Applied Behavior Analysis or Intensive Behavior Intervention services if the service provider uses evidence-based practices and the services promote positive social behaviors and help address issues with learning and social interactions.

2. In order to purchase Applied Behavior Analysis or Intensive Behavior Intervention services, parents of children receiving services must participate, as described, in the established intervention plan.

3. Applied Behavior Analysis or Intensive Behavior Intervention services may not be used for purposes of providing respite, day care, or school services, or solely as emergency crisis services. These services, when identified in the Individualized Family Services Plan/Individual Program Plan, are available through other appropriate providers.

4. Once a consumer's treatment goals, as identified in their Individualized Family Services Plan/Individual Program Plan, have been achieved, regional centers will discontinue purchasing a particular Applied Behavior Analysis or Intensive Behavior Intervention service. The planning team must review progress regularly and change the service if it is not effective.

5. Regional centers will evaluate the Applied Behavior Analysis or Intensive Behavior Intervention hours for each consumer at least every six months.

M. Early Start – Eligibility Criteria ($15.5 million)[1]

The Early Start program in California provides services to infants and toddlers under the age of 3 who are 'developmentally delayed' or have an 'established risk' or are 'at high risk' of a developmental delay. For toddlers who are 'developmentally delayed', this proposal would limit eligibility for entry to the Early Start program after 24 months of age to only those toddlers who have a 50% or greater delay in one domain, or, 33% or greater in two domains. The current threshold is 33% in one domain regardless of age. The age of the infant/toddler at the time of the initial referral will be the age for consideration of eligibility.

Under the $100 million cut, eligibility for toddlers aged 24 months or greater who were 'at risk' of a developmental delay was eliminated. Elimination of eligibility for Early Start services for 'at risk' infants and toddlers was proposed under the $234 million cut. However, a new prevention program was authorized to provide specific services to infants and toddlers affected by this change, as described in the next proposal.

N. Early Start Program Proposals ($19.5 million)

This set of proposals limits services and eligibility for the Early Start program and establishes an alternative program that may be available for consumers no longer eligible for the Early Start program, as follows:

1. Beginning October 1, 2009, and with the exception of durable medical equipment, regional centers will not purchase services that are not required under the federal Early Start grant program. These services include: child care, diapers, dentistry, interpreters, translators, genetic counseling, music therapy, and respite services not related to the developmental delay.

2. The Department will establish a Prevention Program to be available at each regional center for infants and toddlers who do not meet the federal Early Start Program or Lanterman Act eligibility requirements. The prevention program will at a minimum include intake and assessment, case management, and referral to appropriate generic resources. During their participation in the prevention program, if an infant or toddler becomes eligible for the federal Early Start program or Lanterman Act services, regional centers will be able to serve them in those programs.

3. Beginning October 1, 2009, current or prospective infants and toddlers who are 'at risk' for developing a developmental disability will not be eligible for Early Start services. However, services for these infants and toddlers may be available through the new prevention program as described above.

[1] Savings includes $13.4 million in purchase of service and $2.1 million in Regional Center Operations

O. Early Start – Use Private Insurance ($6.5 million)

As is currently required of families with children over 3 years of age, this proposal would require parents of children under 3 to ask their private insurance or health care service plan to pay for medical services covered by the insurance or plan. Intake and assessment will remain free.

P. Expansion of In-Home Respite Agency Worker Duties ($3.0 million)

This proposal would allow respite workers to assist consumers with colostomies/ileostomies, catheters, and gastrostomies, consistent with the abilities of trained day program staff. These duties are currently performed in the home by licensed professionals at significantly greater cost. The respite worker must be trained by a licensed professional and will receive an increase in compensation of $.50/hour for the time performing these duties.

Q. Parental Fee Program ($900,000)

Parents of children under the age of 18 living in any out-of-home care arrangement (e.g. community care facility, developmental center, etc.) pay a monthly fee that varies by family size and income. These fees have not been updated since 1989, except for an increase in the maximum fee amount in 2003. This proposal updates the fee using the most current United States Department of Agriculture data on the cost of raising children. Parents with income below the current Federal poverty level will not be assessed a fee. The fee increase for maximum fee would increase from $662 to $1,875 per month for the highest income families. (For example, a family of four making $146,000 will be assessed the maximum fee.) The children currently in an out-of-home care arrangement will be phased-in over three years, with one-third of the increase each year. Parents whose children move to an out-of-home care arrangement after July 1, 2009 will pay the full updated fee amount.

R. Individual Choice Budget (no savings until implemented)

The Department, in consultation with stakeholders, will develop a new service delivery model that provides consumers and families with an "Individual Choice Budget." This new service delivery model will provide individuals with resources to obtain quality services and supports within a defined budget, while providing choice and flexibility that, in total, saves money in purchase of service expenditures. At such time as this model is implemented and is deemed by the Department to be achieving specific levels of savings, some or all of the cost savings strategies in the following sections (respite service standards and temporarily suspended services) will sunset. . The Department will continue to meet with stakeholders to further develop and refine this proposal.

S. Respite Program- Temporary Service Standards ($4.8 million)

This proposal establishes specific standards to be used by regional centers in authorizing respite services:

1. Regional centers may purchase respite services when the needs of a consumer are greater than that of an individual of the same age without developmental

disabilities. Regional centers can grant exemptions to this rule under certain circumstances.

2. Consistent with the need for respite services established in the Individualized Family Services Plan/Individual Program Plan, no more than 21 days of out-of-home respite services in a fiscal year, or 90 hours of in-home respite services in a three-month period, may be purchased by a regional center. Regional centers can grant exemptions to this rule under certain circumstances.

3. Day care services cannot be used in-lieu of respite services.

These standards will be lifted upon certification of the Director of DDS that the Individual Choice Budget has been implemented and will result in state budget savings sufficient to offset the costs of sun setting the standards.

T. Temporarily Suspend Services ($27.4 million)

The following services will be temporarily suspended pending development of the Individual Choice Model, as described above, that achieves a level of savings sufficient to offset the costs associated with providing these services. Although these remain important services, the current fiscal situation warrants this action until the alternative Individual Choice Budget savings proposal is implemented.

1. Social/recreation activities, except those vendored as community-based day programs.

2. Camping services and the associated travel.

3. Educational services for minor, school-aged children.

4. Non-medical therapies (specialized recreation, art, dance, music, etc.)

Exemptions may be granted by the regional center director in limited and unique circumstances.

This suspension of services will be lifted upon certification of the Director of DDS that the Individual Choice Budget has been implemented and will result in state budget savings sufficient to offset the costs of providing the suspended services.

U. Quality Assurance Consolidation ($2.0 million)

Funding for two separate quality assurance studies will be combined and reduced to fund an improved unified quality assurance system that will be implemented by January 1, 2010. The existing studies include the 'Movers Study' which evaluates consumer satisfaction for individuals who have moved from a developmental center into a community based setting, and the Life Quality Assessment (LQA) which surveys consumers in the community regarding their quality of life.

V. Suspend Wellness and Physician Training Program ($1.3 million)

The Wellness and physician training program funding will be suspended. Wellness funds were used by regional centers for development and implementation of new clinical services and training for consumers, families, and providers. Physician training included contracts with University of California medical schools for various trainings provided to health care professionals on developmental disabilities.

W. Eliminate Triennial Quality Assurance Review ($1.0 million)

Regional centers are currently funded to perform quality assurance evaluations of community care facilities at least once every three years. The funding for these triennial evaluations will be eliminated. However, regional center will maintain other quality assurance activities, including quarterly consumer visits (two must be at the consumers' place of residence), and annual facility monitoring visits. In addition, the California Department of Social Services conducts annual licensing visits of these facilities.

X. Reduction in One Time Regional Center Funding ($3.5 million)

Annually, the Department provides limited funds to regional centers with specific costs associated with required office expansions or relocation needed to better serve consumers. This proposal further limits the availability of this funding.

Y. Additional Regional Center Operations Budget Savings ($7.0 million)

In addition to the 3 percent cut and the reduction in Operations funding associated with items M, W, and X above, the Regional Centers operations budget will be further reduced by $7.0 million.

The Governor's Budget directs the Department of Developmental Services (DDS) to work with stakeholders over the next few months to develop proposals to achieve targeted savings while maintaining the entitlement and ensuring program and service integrity. Below is an outline of the process that DDS will follow.

Stakeholder Process

1. DDS will continue stakeholder collaboration through attendance at specific organization meetings, upon request.

2. DDS will conduct three stakeholder forums. The forums are scheduled for February 19, 2009 (1:00 - 4:00 pm) in Sacramento; February 27, 2009 in Oakland (3:30 – 6:30 pm); and March 2, 2009 (1:00 – 4:00 pm) in Los Angeles.

3. DDS will convene workgroup meetings beginning the week of February 23, 2009, that will include a representative from statewide stakeholder groups that could be impacted by the DDS reduction.

4. DDS will participate in at least one CDCAN town hall meeting to allow an additional opportunity for input from stakeholders. The date of the town hall meeting has not yet been finalized.

5. All stakeholders may submit ideas and comments in writing to the department. Written input may be submitted electronically to sarah.steenhausen@dds.ca.gov or mailed to the Department of Developmental Services, 1600 9th Street, Room 240, attention: Sarah Steenhausen.

6. Legislative staff will be invited to attend all forums and workgroup meetings. DDS will also conduct legislative staff briefings to provide updates on the stakeholder process.

The information gathered through the forums, town hall meetings, and workgroup discussions will help DDS in the preparation of proposals that the Administration will present to the Legislature for their consideration.

Mark Hutchinson
Chief Deputy Director
Department of Developmental Services
(916) 654-1897

RELATED LINKS

- Information About Regional Centers
- Services Provided By Regional Centers
- Information About Programs and Services
- Eligibility Criteria
- Audits and Other Reports
- Directory of Regional Centers
- Locating Regional Centers by County
- ZIP Code Lookup for Regional Centers in LA County

Stakeholders Meeting Notice

As you know, the State of California faces an unprecedented budget crisis. The Governor's Budget, issued on January 9, 2009, anticipates a significant funding reduction. Over the next few months, the Department of Developmental Services (DDS), working with stakeholders, will develop proposals to achieve targeted savings while maintaining the entitlement and ensuring program and service integrity.

The purpose of the forum is to receive input from consumers, family members, service providers and other stakeholders on possible cost containment strategies, including but not limited to those identified in the Controlling Regional Center Costs Report.

- Stakeholders Process (PDF)
- Stakeholders Input Form (PDF)
- Consumer Friendly Version Input Form (PDF)

The public forums will be held:

Sacramento, California
Thursday, February 19, 2009
Time: 1:00 to 4:00 p.m.
Location: The Department of Health Care Services
East End Complex Auditorium
1501 Capitol Avenue

Consumer Friendly Version (PDF)

Los Angeles, California

Oakland, California
Friday, February 27, 2009
Time: 3:30 to 6:30 p.m.
Location: The Elihu M. Harris State Office Building
1515 Clay Street
(Available in Spanish and Chinese)

Consumer Friendly Versions

(PDF)

Monday, March 2, 2009
Time: 1:00 to 4:00 p.m.
Location: The Ronald Reagan State Office Building Auditorium
300 South Spring Street
(Available in Spanish, Chinese and Vietnamese)

Consumer Friendly Version

These events will also include conference call capability. In addition, Marty Omoto will be hosting a CDCAN town hall teleconference to give stakeholders another opportunity to provide input to the department.

Your voice is important, and we hope you will be able to participate. Written input is also welcome and should be submitted by Friday, March 6th to Sarah Steenhausen at sarah.steenhausen@dds.ca.gov. For additional information, please contact her at (916) 654-1989.

In consideration of attendees who are sensitive to environmental odors created by chemicals and perfumes, please restrict the use of fragrances at this meeting. If disability-related accommodations are required for your attendance or you need materials in alternate formats, please contact Debbie Middleton at (916) 654-1902, or at deborah.middleton@dds.ca.gov.

TERRI DELGADILLO
Director

California Department of Developmental Services
1600 Ninth Street
P. O. Box 944202
Sacramento, CA 94244-2020
Info: (916) 654-1690
TTY: (916) 654-2054

QUICK LINKS

- Laws & Regulations
- Budget Information
- Facts & Stats
- CDER
- DDS Forms
- Publications & Other Resources
- Employment Opportunities
- Public Records Requests
- Appeals, Complaints & Comments
- Small Business and Disabled Veterans Advocates
- Disabilities Advisory Committee
- Español
- Newsroom
- Links
- Contact Us

DDS YouTube Channel

BE PREPARED CALIFORNIA

Get Adobe Reader

Documents identified by PDF (Portable Document Format) requires the Adobe Acrobat Reader to be viewed and printed. If you do not already have the Adobe Reader, it can be downloaded for free from Adobe.

Department of Health Care Services
Responses to CMS's Request for Additional Information on the
1915(i) State Plan Amendment

The following are the Department of Health Care Services' (DHCS) responses to the Centers for Medicare and Medicaid Services' (CMS) Request for Additional Information (RAI) on California's 1915(i) Home and Community-Based Services (HCBS) State Plan Amendment (SPA). The responses follow the order of the issues raised in CMS' March 26, 2010 letter.

General Questions

1. *Public Notice – please provide public notice information for this State Plan Amendment.*

State's Response:

The 1915(i) SPA originated out of a series of meetings in the spring of 2009 with the Department of Developmental Services (DDS) and its Budget Advisory Committee, a large group of stakeholders representing consumers, families, regional centers and service providers throughout the State. Attached to this response is the notice sent to stakeholders describing the process that was used to develop proposals to achieve budgetary savings. The announcement of the three public forums referenced in the notice was also posted on DDS' website. Along with other proposals, the pursuit of a 1915(i) SPA was presented to the State Legislature in a series of legislative hearings in 2009 which culminated in the passage of legislation, signed by the Governor, mandating the State seek CMS' approval of a 1915(i) SPA. Information about the intent to submit a 1915(i) SPA was also posted (July 2009) on the Department of Developmental Services website. This process and public notice requirements were also discussed in a phone call with CMS on February 13, 2012.

2. *Changes to the CMS-179.*

State's Response:

Revised as suggested.

3. *Tribal Consultation.*

State's Response:

Please see attached Tribal Notification.

Coverage –Attachment 3.19-C

1. Section 6086 of the Deficit Reduction Act (2005) allows for the provision of home and community-based services for individuals with less than an institutional level of care under Section 1915(i) authority. The State may use needs-based criteria and risk factors to ensure that services reach the intended population, e.g., people with developmental disabilities. However these services must be made available to all individuals who meet these criteria regardless of diagnosis or delivery system.

State's Response:

The State revised its needs-based criteria as follows:

For the period from October 1, 2009 to September 30, 2010, the individual has a need for assistance demonstrated by:

A need for habilitation services, as defined in Section 1915(c)(5) of the Social Security Act (42 U.S.C. § 1396 *et seq.*), to teach or train in new skills that have not previously been acquired, such as skills enabling the individual to respond to life changes and environmental demands (as opposed to rehabilitation services to restore functional skills); and,

A likelihood of retaining new skills acquired through habilitation over time; and,

A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential, that continues, or can be expected to continue, indefinitely; and

The existence of significant functional limitations in at least three of the following areas of major life activity, as appropriate to the person's age:

Receptive and expressive language;

Learning;

Self-care;

Mobility;

Self-direction;

Capacity for independent living.

Commencing October 1, 2010, in addition to the needs identified above, the individual must also have a diagnosis of a developmental disability, as defined in Section 4512 of the Welfare and Institutions Code and Title 17, California Code of Regulations, §54000 and §54001. Further, "economic self-sufficiency" will also be considered an area of major life activity for the purpose of identifying significant functional limitations.

2. Pg. 1, #3 -- The State indicated the operating agency for the HCBS State Plan Services is the Department of Developmental Services (DDS). Please explain how the State intends to provide the services to eligible beneficiaries absent a developmental disability. Revise the function distribution chart on page 4 as appropriate.

State's Response:

Had the SPA been approved prior to 10/1/10, the State was equipped to coordinate services, through resources managed by DHCS' Long-Term Care Division, for those eligible individuals without developmental disabilities. Effective 10/1/10, the eligibility criteria was modified such that services in the SPA are available only to individuals with developmental disabilities. It is important to note that since approval of the SPA did not occur prior to 10/1/10, only individuals with developmental disabilities, as authorized by State statute, received services identified in the SPA prior to 10/1/10. Therefore, the change in eligibility criteria effective 10/1/10 did not result in a loss of services for individuals without developmental disabilities because the SPA was not implemented prior to that date.

The function distribution chart has been modified.

3. Pg. 4, #1 -- Please explain how the State will provide for evaluations/re-evaluations for individuals served outside the Regional Centers without developmental disabilities. Assure that the qualifications of the providers performing this function take into account all individuals who may meet the needs-based and risk criteria.

State's Response: As noted in the response to question #2, the State, through DHCS' Long-Term Care Division, would have coordinated needed evaluations/revaluations for individuals without developmental disabilities prior to 10/1/10.

4. Pages 4 & 5, #4 – The needs-based eligibility criteria should be described first (e.g. "the individual has a need for assistance…". Regarding the proposed risk

factors, as noted previously, the State must clearly explain the appropriate risk factors in lieu of the proposed language.

State's Response: The needs-based eligibility criteria has been revised as noted in response to question #1.

5. *Page 6, #5 – Please clarify and revise the proposed Differences Between Level of Care Criteria chart to reflect the needs-based criteria and risk factors, especially the section on State Plan HCBS Needs-based eligibility criteria. Also, the State needs to more specifically summarize the criteria in the nursing facility column.*

State's Response:

Revised as suggested. Please see revised "Differences Among Level of Care Criteria" chart beginning on Page 8 of the SPA preprint.

6. Page 8, #8 – Please add language that HCBS settings are not ICFs/MR. Please also include additional details regarding how the home-like nature of a residential setting is determined (e.g. free access to food, visitors, lockable doors, etc.) Are all facilities listed as providers serving four people or fewer, inducing out-of-state facilities?

State's Response

Please see revised page ten of the SPA preprint regarding home-like residential settings, including the criteria used to determine if facilities that house four or more people will be considered home-like environments.

7. Page 9, #3 and #4 – Does the State allow experience in fields other than developmental disabilities to substitute for education qualifications?

State's Response: The SPA (page 11 #3 and #4) states that case management experience in the developmental disabilities field or a related field may be substituted for education qualifications.

8. Page 9, #5 – Please revise this text as it appears to address only the needs of people with developmental disabilities. When an "individual is assigned a case manager", does he/she have the opportunity to freely choose from among qualified case managers? Please also describe in detail how the eligible beneficiary can determine who is included in the service planning process and how providers participate in this process for a new enrollee.

State's Response:

Had the SPA been implemented prior to 10/1/10, the State was prepared to coordinate the provision of case management for individuals without developmental disabilities. See response to #2 for further information.

Revisions have been made to the SPA (page 11, #5) to indicate *"Individuals may choose among qualified service coordinators."*

For a new enrollee, potential providers of service may, or may not, be at the initial meeting to plan services. This will depend on the individual enrollee's circumstances and preference. The enrollee may invite any one they would like to the service planning meeting(s). At a minimum, the initial service planning meetings will involve the enrollee, their legal representative if any, and the case manager. As these initial meetings identify the enrollee's service needs and preferences, other support persons and/or interdisciplinary staff often join the process.

9. Page 10, # 7 – Please add language to indicate that the sample of service plans to be annually reviewing (not necessarily IPP's) is representative.

State's Response:

Revisions (see page 12) have been made to indicate a representative sample of service plans will be reviewed biennially.

10. Page 10, #7 and #8 - How can DDS, in conjunction with DHCS, be the only agency with IPP's on file, provided the State adjusts its needs-based/risk criteria? Similarly, how can the Regional Centers be the only entity to house service plans?

State's Response:

As noted in response to question #2, the State was prepared to coordinate the provision of services for individuals without developmental disabilities prior to 10/1/10.

11. Page #11, Habilitation, general description – Based on provider qualifications, it appears that a specific behavioral habilitation component is included in the habilitation service. If so, it should be a separate component service under habilitation, with an appropriate rate methodology. It also appears that mobility training is a separate component of Habilitation (e.g. Mobility Habilitation Training).

State's Response:

Descriptions of services, including "Habilitation" have been revised consistent with the State's HCBS Waiver for people with developmental disabilities,

approved effective 3/29/12. Specifically, "Habilitation – Behavioral Intervention Services" is now a distinct service and "Mobility Related Day Services" is a separate component of "Habilitation – Day Services."

12. Habilitation, general – With regards to provider types, please explain how all Habilitation services are available to people without developmental disabilities (e.g. creative arts program). Please also include complete information with regards to specific licensing and certification requirements for all providers. Some sections are blank, while others simply list business license.

State's Response:
Prior to 10/1/10, the State was equipped to coordinate services for individuals without developmental disabilities (see response to question #2 for more information.)

The SPA has been revised to reflect the applicable licensing/certification requirements for all providers. As reflected in the SPA, consistent with State law, additional licensure or certification requirements (beyond a business license) are not applicable to all types of providers.

13. Habilitation, general – Please add a statement indicating that any services provided to family members are for the benefit of the HCBS recipient.

State's Response:

The definition of "Habilitation – Behavioral Intervention Services" includes the following statement *"Services may be provided to family members if they are for the benefit of the recipient."*

14. Page 11, Home-Based Habilitation – What types of HCBS "facility" would be required to meet the Life Safety Code requirements? Are the descriptions of the types of Supported Employment (Group, Individual, Pre-Vocational, Supported Habilitation) inclusive of the language cited in the California Welfare and Institutions Code? Regarding the Supported Employment service and the Pre-vocational services, the State should delete any language limiting the service to people 18 years of age, or older, since Section 1915(i) of the Act does not provide for such a limitation. Also, all the language in this section should be changed to indicate the service description is inclusive of a set of services, rather than "includes" certain services. The State may wish to complete the section for additional needs-based criteria for receiving the Habilitation service.

State's Response:

The text regarding Life Safety Code requirements was in error and has been deleted. Pre-Vocational and Supported Employment are now reflected as separate services consistent with the State's HCBS Waiver for people with

developmental disabilities, approved effective 3/29/12. The definitions for these services have been revised as suggested.

15. Pg 14, Foster Family Homes – Please add a statement indicating payment for services will not be duplicated or supplanted through Medicaid funding.

State's Response:

The statement above has been added to the SPA. Please see Page 15.

16. Page 16 – Please explain how Regional Centers vendorize for the purposes of this State Plan Amendment.

State's Response:

The vendorization process is the process for identification, selection, and utilization of service providers based on the qualifications and other requirements necessary in order to provide services. The vendorization process allows regional centers to verify, prior to the provision of services to individuals, that a provider meets all of the requirements and standards specified in regulations.

Regional centers are responsible for ensuring that the applicant meets licensing, certification, education, staffing and other Title 17 requirements for vendorization and approving vendorization based upon their review of the documentation submitted by the applicant.

17. Pg 17 – Please provide more detail about the Specialized Residential Facilities (DSS licensed) and the Residential Facilities (Supplemental Program Support).

State's Response:

Specialized Residential Facilities primarily serve consumers who require more social/emotional and/or behavioral and health supports (or a combination thereof) than can be provided within the rate structure of the Alternative Residential Model (ARM). Dependent upon each individual consumer's need(s), these homes provide a more intensive staff to consumer ratio and more experienced and/or professionally qualified/educated staff (e.g., certified behavior analyst) to address both scheduled and unpredictable consumer needs. As noted in the accompanying cover letter, the State is requesting that approval for services provided by these facilities be considered separately from the other services/providers in the SPA.

Supplemental Program Support services are provided to an individual consumer, for a limited period of time with close monitoring of the efficacy of the support, to

maintain the consumer in their home setting while experiencing a need for increased support/services due to a behavioral or health related incident.

18. Page 17 – Regarding the incidental services provided by a DSS-Licensed Specialized Residential Facility", how are these services (home health care, physical therapy, occupational therapy, etc.) funded?

State's Response:

If these services are not included in the facility's program design and rate, they may be provided directly by another individual or agency, with payment made through the Medi-Cal program. In the alternative, should the incidental need not fall under the Medi-Cal state plan program (e.g., differs in amount, scope, or duration), the residential provider will fund the service consistent with the terms of its program design and approval as a qualified provider of 1915(i) services.

19. Page 21, Infant Development Program – Please explain the intersection with IDEA, and verify non-duplication of services. How does the applicable prohibition on services delivered through the Individuals with Disabilities Education Improvement Act (IDEA) and Section 110 of the Rehabilitation Act of 1973 in Section 1915(i) impact any services provided through the SPA?

State's Response:

This provider type has been removed from the SPA.

20. Page 26, Respite Care – Are there any mechanisms in place for individuals not served by the Regional Centers to procure vouchered respite care? The State should complete the applicable self-direction portion of the template for this service.

State's Response:

The vouchered option for Respite and other services has been removed from this application.

21. Page 27 – Under "Specify Limits," the State should clarify that home respite may be provided outside the dispensation of a Regional Centers.

State's Response:

As noted in response to question #2, the State was prepared to coordinate the provision of services for individuals not served by regional centers (e.g. individuals without developmental disabilities) prior to 10/1/10.

22. Page 30-regarding the Provider Qualifications, how can all providers be vendored by a Regional Center?

State's Response:

As noted in response to question #16, regional centers are responsible for ensuring that providers meet licensing, certification, education, staffing and other Title 17 requirements for vendorization and approving vendorization based upon their review of the documentation submitted by the applicant.

23. Page 31 – Personal Care –the provider qualifications indicate this service includes vehicle adaptations. Please explain. Also, Personal Emergency Response Systems are likely more appropriate as a Habilitation service. In limits on the service, please indicate that personal care services will be a continuation of services beyond the amount, duration and scope of the regular State plan benefit.

State's Response:

The SPA has been revised and no longer includes "Personal Care" as a service. Additionally, "Personal Emergency Response Systems" and "Vehicle Modifications" are now reflected as distinct services with an effective date of 10/1/10.

24. Page 33- Homemaker-In limits on the service, please indicate that personal care services will be a condition of services beyond the amount, duration and scope of the regular Sate plan benefit. Also, how can all providers be vendored by a Regional Center?

State's Response:

The SPA has been revised to contain the following statement: *"Homemaker services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit."* Additionally, although all providers are vendored by regional centers, the State would have arranged for the provision of services to people without developmental disabilities had the SPA been approved prior to 10/1/10. (See response to question #2 for more information.)

25. Page 34 – Please note that Home Health Aide services will be a continuation of services beyond the amount, duration and scope of the regular State plan benefit. How can all providers be vendored by a Regional Center?

State's Response:

The SPA has been revised to contain the following statement: *"Home Health Aide services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit."* Although all providers are vendored by regional centers, the State would have arranged for the provision of services to people without developmental disabilities had the SPA been approved prior to 10/1/10. (See response to question #2 for more information.)

26. Page 35 – Please clarify the intersection of the Adult Day Health Care service with the present configuration in the approved State plan. Is transportation included in the regular benefit? Also, please specify limits on this service and note that services would be a continuation of services beyond the amount, duration and scope of the regular State plan benefit.

State's Response:

The SPA has been updated to indicate: 1) effective 4/1/12, the new name for this service is Community Based Adult Services (CBAS); 2) this service will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit; and 3) transportation is included in the benefit.

27. Page 36, Case Management -- The SPA indicates that case management is provided through the TCM State Plan benefit. What target groups are included in the State plan that may be served through this amendment? Regarding the provision of "any" service by a recipient's conservator, legal guardian or relative, please explain how only the Regional Centers would monitor this arrangement. Since case management is not a State plan HCBS service, please remove case management from the services section.

State's Response:

Had the SPA been implemented prior to 10/1/10, the State was prepared to coordinate the provision of services, including case management ,for individuals without developmental disabilities. See response to #2 for further information. Case management has been removed from the services section.

28. Page 40 – Please reconfigure the chart based on the need to expand the group of individuals who can receive the HCBS State plan services. This includes revising the "who" and "what" in the Monitoring Activities and Monitoring Responsibilities sections. Under Evidence, the State needs to articulate what "results" will serve as sound evidence. The Evidence section must also include documentation that samples are representative for all requirements, including confidence intervals and sample size. Please explain what sort of monitoring reports will be used to assess the adequacy of service plans and how these reports will be evaluated. Regarding the verification of provider qualifications, elaborate on the Data Elements associated with each of the monitoring activities. Please describe what sort of oversight DHCS will impose on the various

agencies required to track whether or not providers meet provider qualifications. CMS urges the State to avail itself of technical assistance from our NQE contractor to strengthen this section, including the section on remediation and systems improvement, and how the State evaluates the effectiveness of system change.

State's Response:

During the HCBS Waiver renewal process, the State worked with CMS' quality contractor to develop the Quality Improvement Strategy (QIS) reflected in the Waiver approved 3/29/12. Using information obtained from this assistance, the quality management portion of the SPA has been modified to indicate the performance measures in each category and information regarding sample size, confidence intervals and data elements used to verify performance on the required assurances.

Standard Funding Questions

29. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State Plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of any payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (e.g., general fund, medical services account, etc.).

State's Response:

Providers retain 100% of the payments. They do not return any portion of payments (Federal or State share) to the State, any local governmental entity, or any other intermediary organization.

30. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any

of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;
(ii) the operational nature of the entity (state, county, city, other);
(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority; and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

State's Response:

The state share of Medicaid payments for 1915(i) services is funded from appropriations made annually to DDS through the State Budget Act for the full amount of the services provided. There are no local government level sources of funds utilized as the non-federal share. DDS directly incurs the full cost of 1915(i) services. The non-federal share for these costs is appropriated directly to DDS through the State budget process. The source of all non-federal, or matching, funds used in computing 1915(i) costs is from State revenues. Therefore, no federal funds are used to match other federal funds.

(i) DDS will certify to DHCS, the State Medicaid Agency, expenditures eligible for Federal Financial Participation (FFP).

(ii) DDS is an agency of the State of California.

(iii) The total amounts certified by DDS will vary depending on SPA enrollment. For FY 09/10, expenditures are estimated at approximately $239 million ($147 million FFP).

(iv) The certifying agency (DDS) does not have general taxing authority. The State of California has general taxing authority.

(v) DDS will continue to receive annual appropriations from the state legislature through the budgetary process for these services.

Payments to providers for authorized services are processed through the Uniform Fiscal System (UFS). The system establishes and tracks authorization and billing data including provider number, purchase authorization number, consumer identification and eligibility information, service type, service rate, claim amount, and claim date. 1915(i) services will not be paid unless the appropriate authorization and billing data are present. Once paid, all service authorization

and billing data necessary to support the provider claims is transmitted to DDS to provide a complete audit trail. Vendors, regional centers and DDS are required to maintain documentation to support financial accountability in accordance with federal requirements. In addition to the controls contained in UFS to prevent possible erroneous payments, oversight of appropriate claiming also includes provider audits conducted by regional centers and DDS with DHCS oversight.

31. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

State's Response:

Payments made under this SPA will constitute payment in full. There will be no supplemental or enhanced payments.

32. For clinic or outpatient hospital services, please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

State's Response:

Services under this SPA are not clinic or outpatient hospital services.

33. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

State's Response:

There are no governmental providers in this SPA. No provider payments exceed the reasonable costs of providing services.