

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
11-040

2. STATE
CA

FOR: HEALTH CARE FINANCING ADMINISTRATION

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, 2011

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:
a. FFY 12 \$10,860,000
b. FFY 13 \$11,940,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, pages 65-66
Attachment 3.1-C, pages 1-27

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*):
None

10. SUBJECT OF AMENDMENT:

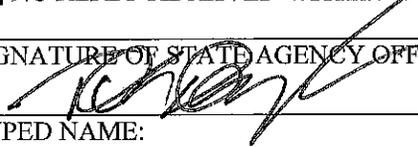
Infant Development program for infants and toddlers

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: **12/27/11**

16. RETURN TO:

**Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.326
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:

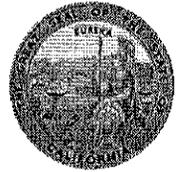
22. TITLE:

23. REMARKS:



TOBY DOUGLAS
DIRECTOR

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



EDMUND G. BROWN JR.
GOVERNOR

DEC 29 2011

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

STATE PLAN AMENDMENT 11-040

Dear Ms. Nagle: *Gloria*

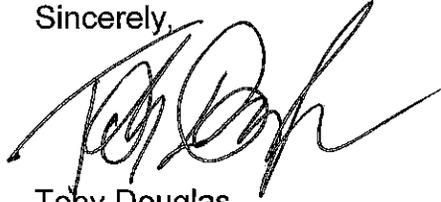
The purpose of this letter is to amend the California Department of Health Care Services (DHCS) State Plan to add services that may be provided under Section 1915 (i) of the Social Security Act. State Plan Amendment (SPA) Transmittal # 11-040 extends Medi-Cal coverage for existing infant development programs provided to Medi-Cal eligible infants and toddlers with a developmental delay or a condition that has a high probability of leading to a developmental delay. Medi-Cal eligible infants and toddlers who meet the criteria above and who do not meet the criteria for institutional long-term care services will be covered under this State Plan option. Currently, these services are provided solely with State funds.

DHCS has provided an informational notice to Indian Health programs regarding this SPA. DHCS does not anticipate that this SPA will have an effect on the Indian Health Programs because it makes no changes to providers of services or rates of payment for services, nor does it impact Indian Medi-Cal infants and toddlers with a developmental delay or a condition that has a high probability of leading to a developmental delay because it makes no changes to current services or eligibility for services. A copy of the notice is enclosed.

We would like to extend our deep appreciation to Cynthia Nanes and Ellen Blackwell for their availability, patience and guidance in this effort. Their professional collaboration provided our staff and staff from the Department of Developmental Services with the direction and support needed to craft this SPA properly.

If you have any questions or concerns, please contact John Shen, Chief, Long-Term
Care Division, Department of Health Care Services at (916) 440-7552.

Sincerely,



Toby Douglas
Director

Enclosures

cc: John Shen
Chief, Long -Term Care Division
California Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95841

State Plan Under Title XIX of the Social Security Act
STATE/TERRITORY: CALIFORNIA

REIMBURSEMENT METHODOLOGY FOR INFANT DEVELOPMENT PROGRAMS

The rate for infant development programs is set using actual costs. Under this methodology, new vendors are assigned a “new vendor” rate, until a permanent rate is established, within the upper and lower limits range of rates, using actual cost information as describe below. Note: Effective 7/1/03, pursuant to State law, rates for new providers are fixed at the new vendor rate.

For these providers, the cost based rates are calculated using 12 consecutive months of allowable costs related to services to consumers and actual hours of consumer attendance.

The allowable costs used in determining the rates include the following:

- The gross salary, wages, and limited fringe benefits, including overtime and staff relief time, for administrative, supervisory, and direct service staff;
- Operating expenses limited to the following cost categories:
 - Accounting and bank fees
 - Communication costs, i.e., telephone, telegraph, teletype, centrex, telepak, postage, message services, facsimiles and TDD
 - Contractual/consultant fees for program operation
 - Limited depreciation costs for facilities, furniture capital improvements
 - General expense costs for furniture and equipment, interest on loans, staff development subscriptions, staff screening and recruitment costs, fees for licenses, certifications, registrations or permits, accreditation/association dues and/or fees, costs for providing or preparing information related to the vendored service which is used as general information to the consumers or to the authorized consumer representatives, local business fees or taxes, costs related to inoculations or clinical tests of an employee, and fuel and oil;
- Insurance costs;
- Janitorial fees;
- Legal fees;
- Maintenance costs for repair and upkeep of furniture and equipment, vehicles, facilities and grounds;
- Office and program supply costs for items which are used by or on behalf of the consumers;
- Rental and lease costs for furniture, equipment, vehicles, and facilities;
- Staff training costs;
- Travel costs for consumer or staff travel that is a part of the program curriculum;
- Utility costs;
- Vehicle depreciation costs.
- Allocated portion of costs of management organization (a separate and distinct corporation or entity which operates two or more services) costs, if any, attributable to the operation of the specific service.

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State Plan Under Title XIX of the Social Security Act
STATE/TERRITORY: CALIFORNIA

REIMBURSEMENT METHODOLOGY FOR INFANT DEVELOPMENT PROGRAMS

(continued)

The following costs are not allowed:

- Camperships, student aid funds and scholarships;
- Consumer entertainment, admission fees, moving expenses;
- Contractual/consultant fees for individual services which can be obtained through a generic agency and which the generic agency is legally responsible to provide;
- Depreciation costs for furniture, equipment, facilities or vehicles that are donated, secured or purchased through government grants;
- Depreciation costs for owned land;
- Donated services, facilities, furniture, equipment, or vehicles;
- Donations to other agencies;
- Employee bonuses and commissions;
- Facility, furniture, equipment, or vehicle rental or lease costs associated with items which are owned by a management organization, its affiliates or a commonly owned entity; and are leased or rented back to the management organization, its affiliates or a commonly owned entity, or the services it operates, when submission of such costs would result in the vendor being reimbursed twice for the same costs;
- Federal/state income tax and penalties or fees associated with payment of federal or state income taxes;
- Fund raising costs;
- Gifts for consumers or employees;
- Legal fees directly related to a consumer, or expenses for the prosecution of claims against the regional center or state agencies;
- Payroll tax penalties.

The total of the allowable costs above for each vendor is then divided by the vendor's actual hours of consumer attendance to determine the hourly rate per consumer for a permanent payment rate.

b) The calculation for the range of rates is described below.

- The mean of rates of all like service providers is determined by adding the rates calculated in a) above for all vendors and dividing the sum of these rates by the total number of providers.
- The mean is then multiplied by 50 percent to determine the range. This range is then compared to the range determined for like services in fiscal year 1991-1992 (base year), and adjusted for any COLA. The lower of these two ranges is then divided by two and used for further calculations. The upper limit is determined by adding the amount calculated in the step above to the mean. Conversely, the lower limit is determined by subtracting the amount calculated in the step above from the mean.

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1915(i) HCBS State Plan Services Administration and Operation

1. **Program Title** (optional): California 1915(i) for Infants and Toddlers

2. **State-wideness.** (Select one):

<input checked="" type="radio"/>	The State implements this supplemental benefit package statewide, per §1902(a)(1) of the Act.
<input type="radio"/>	The State implements this benefit without regard to the statewideness requirements in §1902(a)(1) of the Act. (Check each that applies):
<input type="checkbox"/>	Geographic Limitation. HCBS state plan services will only be available to individuals who reside in the following geographic areas or political subdivisions of the State. (Specify the areas to which this option applies):
<input type="checkbox"/>	Limited Implementation of Participant-Direction. HCBS state plan services will be implemented without regard to state-wideness requirements to allow for the limited implementation of participant-direction. 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 to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. (Specify the areas of the State affected by this option):

3. **State Medicaid Agency (SMA) Line of Authority for Operating the HCBS State Plan Supplemental Benefit Package.** (Select one):

<input type="radio"/>	The HCBS state plan supplemental benefit package is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program (select one):
<input type="radio"/>	The Medical Assistance Unit (name of unit):
<input type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit (name of division/unit)
<input checked="" type="radio"/>	The HCBS state plan supplemental benefit package is operated by (name of agency)
	The Department of Developmental Services (DDS)
	a separate agency of the State that is not a division/unit of the Medicaid agency. 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.

The State assures that in accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration or supervision of the state plan. When a function is performed by other than the Medicaid agency, the 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.

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

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Disseminate information concerning the state plan HCBS to potential enrollees	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2 Assist individuals in state plan HCBS enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3 Manage state plan HCBS enrollment against approved limits, if any	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4 Review participant service plans to ensure that state plan HCBS requirements are met	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5 Recommend the prior authorization of state plan HCBS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6 Conduct utilization management functions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7 Recruit providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8 Execute the Medicaid provider agreement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9 Conduct training and technical assistance concerning state plan HCBS requirements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10 Conduct quality monitoring of individual health and welfare and State plan HCBS program performance.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

This 1915(i) SPA employs an Organized Health Care Delivery System (OHCDS) arrangement. The Department of Developmental Services (DDS) is the OHCDS.

DDS Meets the Regulatory Definition of an OHCDS. Federal Medicaid regulations define an OHCDS as “a public or private organization for delivering health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.” 42 C.F.R. § 447.10(b). The term OHCDS is “open to interpretations broad enough to apply to systems which are not prepaid organizations.” See State Medicaid Directors dated December 23, 1993. An OHCDS “must provide at least one service directly (utilizing its own employees, rather than contractors).” *Id.* “So long as the entity continues to furnish at least one service itself, it may contract with other qualified

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providers to furnish Medicaid covered services.” *Id.*

The Department directly provides (utilizing its own employees) Intermediate Care Facility, Nursing Facility and Acute Care Facility services through its state-operated developmental centers. In addition, the Department contracts with 21 not-for-profit corporations called regional centers to provide case management and to act as DDS’s agent in qualifying providers of 1915(i) and other home-and-community-based services. Therefore, DDS meets the requirement that an OHCDS provide at least one service directly through its own employees and contracts with other qualified providers to furnish other covered services.

There are adequate safeguards to ensure that OHCDS subcontractors possess the required qualifications and meet applicable Medicaid requirements e.g. maintenance of necessary documentation for the services furnished. The required qualifications for 1915(i) services providers are set forth in state law (State Welfare and Institutions Code and/or Government Code), DDS regulations, and the 1915(i) SPA. Under state law, regional centers are responsible for ensuring that providers meet these qualifications. A prospective provider must submit to the regional center the packet of information required by State regulations based on type of service provided, ex. copy of current license, program design, etc., to the regional center for review and approval to qualify as a provider of 1915(i) services. A vendor agreement is executed and signed and vendorization status granted to qualified providers.

The OHCDS arrangements preserve participant free choice of providers. Free choice of providers is a hallmark of the California system. Recipients of 1915(i) services select their providers through the person centered planning process orchestrated by the regional centers, which culminates in the development of an individual program plan (signed by the beneficiary) delineating the services to be provided and the individual’s choice of provider of such service(s). If an individual’s choice of provider is not vendorized, they must go through the regional center vendorization process to ensure that they meet all necessary qualifications. If a provider meets the qualifications, the regional center must accept them as a vendored provider in the OHCDS.

1915(i) providers are not required to contract with an OHCDS in order to furnish services to participants. Although the open nature of the OHCDS means that virtually all providers will be part of the OHCDS, in the event a provider does not want to affiliate with the OHCDS and regional center, they may go directly to the Department of Health Care Services to execute a provider agreement. However, under state law, the process for qualifying a vendor to provide home-and-community based services to an individual with developmental disabilities is through the regional center.

The OHCDS arrangement provides for appropriate financial accountability safeguards.

According to the State Medicaid Manual, when utilizing an OHCDS to provide waiver services, payment is made directly to the OHCDS and the OHCDS reimburses the subcontractors. Providers of 1915(i) SPA services submit claims to the regional center for services delivered to the beneficiary, pursuant to the individual program plan. The regional center reviews the claim (units of service, rate, etc), pays legitimate claims, and submits the claim of payment to DDS as the OHCDS. The OHCDS reimburses the regional center for the actual cost of the service, certifies the expenditures and submits a claim for the federal financial participation to the Department of Health Care Services. DDS does not “add on” to the actual costs of services incurred by and reimbursed to the regional centers.

The costs for administrative activities are not billed as part of the OHCDS payment and are claimed

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separately at the appropriate administrative rate.

- 5. **Conflict of Interest Standards.** The State assures it has written conflict of interest standards that, at a minimum, address the conduct of individual assessments and eligibility determinations.
- 6. **Appeals.** The State allows for 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 HCBS state plan services.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually. *(Specify):*

Annual Period	From	To	Projected Number of Participants
Year 1	10/1/2111	9/30/2012	3800
Year 2	10/1/2112	9/30/2113	4000
Year 3	10/1/2113	9/30/2114	
Year 4	10/1/2114	9/30/2115	
Year 5	10/1/2115	9/30/2116	

2. Optional Annual Limit on Number Served. *(Select one):*

<input checked="" type="radio"/>	The State does not limit the number of individuals served during the Year.																								
<input type="radio"/>	The State chooses to limit the number of individuals served during the Year. <i>(Specify):</i>																								
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Annual Period</th> <th style="width: 20%;">From</th> <th style="width: 20%;">To</th> <th style="width: 45%;">Annual Maximum Number of Participants</th> </tr> </thead> <tbody> <tr><td>Year 1</td><td></td><td></td><td></td></tr> <tr><td>Year 2</td><td></td><td></td><td></td></tr> <tr><td>Year 3</td><td></td><td></td><td></td></tr> <tr><td>Year 4</td><td></td><td></td><td></td></tr> <tr><td>Year 5</td><td></td><td></td><td></td></tr> </tbody> </table>	Annual Period	From	To	Annual Maximum Number of Participants	Year 1				Year 2				Year 3				Year 4				Year 5			
Annual Period	From	To	Annual Maximum Number of Participants																						
Year 1																									
Year 2																									
Year 3																									
Year 4																									
Year 5																									
<input type="checkbox"/>	The State chooses to further schedule limits within the above annual period(s). <i>(Specify):</i>																								

3. Waiting List. *(Select one):*

<input checked="" type="radio"/>	The State will not maintain a waiting list.
<input type="radio"/>	The State will maintain a single list for entrance to the HCBS state plan supplemental benefit package. State-established selection policies: are based on objective criteria; meet requirements of the Americans with Disabilities Act and all Medicaid regulations; ensure that otherwise eligible individuals have comparable access to all services offered in the package.

Financial Eligibility

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1. **Income Limits.** The State assures that individuals receiving state plan HCBS are in an eligibility group covered under the State’s Medicaid state plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL).

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

<input checked="" type="radio"/>	The State does not provide HCBS state plan services to the medically needy.
<input type="radio"/>	The State provides HCBS state plan services to the medically needy (<i>select one</i>):
<input type="radio"/>	The State elects to waive the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
<input type="radio"/>	The State does not elect to waive the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Independent evaluations/reevaluations to determine whether applicants are eligible for HCBS are performed (*select one*):

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="radio"/>	By Other (<i>specify</i>):
	Regional centers

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** There are qualifications (that are reasonably related to performing evaluations) for persons responsible for evaluation/reevaluation for eligibility. (*Specify qualifications*):

The minimum requirement for conducting evaluations/reevaluations is a degree in social sciences or a related field. Case management experience in the developmental disabilities field or a related field may be substituted for education on a year-for-year basis.

3. **Independence of Evaluators and Assessors.** The State assures that evaluators of eligibility for HCBS state plan services and assessors of the need for services are independent. They 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
- service providers, or individuals or corporations with financial relationships with any service provider.

4. **Needs-based HCBS Eligibility Criteria.** Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for HCBS state plan services. The criteria take into account the individual’s support needs and capabilities and may take into account the individual’s ability to perform two or more ADLs, the need for assistance, and other risk factors: (*Specify the needs-based criteria*):

Infants and toddlers (birth through two years of age) who meet the criteria below will be eligible to receive, based on individual needs determinations, services under this plan identified as applicable for this eligibility group. Eligible infants and toddlers are those who meet one of the following criteria:

1) Infants and toddlers with a developmental delay in one or more of the following five areas: cognitive development; physical and motor development, including vision and hearing;

communication development; social or emotional development; or adaptive development. Developmentally delayed infants and toddlers are those who are determined to have a significant difference between the expected level of development for their age and their current level of functioning. This determination shall be made by qualified personnel who are recognized by, or part of, a multidisciplinary team, including the parents. A significant difference is defined as a 33-percent delay in one developmental area before 24 months of age, or, at 24 months of age or older, either a delay of 50 percent in one developmental area or a 33-percent delay in two or more developmental areas.

2) Infants and toddlers with established risk conditions, who are infants and toddlers with conditions of known etiology or conditions with established harmful developmental consequences. The conditions shall be diagnosed by a qualified personnel recognized by, or part of, a multidisciplinary team, including the parents. The condition shall be certified as having a high probability of leading to developmental delay if the delay is not evident at the time of diagnosis.

5. **Needs-based Institutional and Waiver Criteria.** 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 HCBS state plan services. 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. *(Include copies of the State's official documentation of the need-based criteria for each of the following):*

- *Applicable Hospital*
- *NF*
- *ICF/MR*

Differences Among Level of Care Criteria

State Plan HCBS Needs-based eligibility criteria	NF	ICF/MR LOC	Hospitalization LOC
<p>Eligible infants and toddlers are those who meet one of the following criteria:</p> <p>1) Infants and toddlers with a developmental delay in one or more of the following five areas: cognitive development; physical and motor development, including vision and hearing; communication development; social or emotional development; or</p>	<p>Skilled nursing procedures provided as a part of skilled nursing care are those procedures which must be furnished under the direction of a registered nurse in response to the attending physician's order. The need must be for a level of service which includes the continuous availability of</p>	<p>Eligible infants and toddlers are those who meet one of the following criteria:</p> <p>1) Infants and toddlers with a developmental delay in one or more of the following five areas: cognitive development; physical and motor development, including vision and hearing; communication development; social or emotional development; or</p>	<p>Skilled nursing procedures provided as a part of skilled nursing care are those procedures which must be furnished under the direction of a registered nurse in response to the attending physician's order. The need must be for a level of service which includes the continuous availability of</p>

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State Plan HCBS Needs-based eligibility criteria	NF	ICF/MR LOC	Hospitalization LOC
<p>adaptive development. Developmentally delayed infants and toddlers are those who are determined to have a significant difference between the expected level of development for their age and their current level of functioning. This determination shall be made by qualified personnel who are recognized by, or part of, a multidisciplinary team, including the parents. A significant difference is defined as a 33-percent delay in one developmental area before 24 months of age, or, at 24 months of age or older, either a delay of 50 percent in one developmental area or a 33-percent delay in two or more developmental areas.</p> <p>2) Infants and toddlers with established risk conditions, who are infants and toddlers with conditions of known etiology or conditions with established harmful developmental consequences. The conditions shall be diagnosed by a qualified personnel recognized by, or part of, a multidisciplinary team, including the parents. The condition shall be certified as having a high</p>	<p>procedures such as, but not limited to, the following:</p> <ul style="list-style-type: none"> • Nursing assessment of the individuals' condition and skilled intervention when indicated; • Administration of injections and intravenous of subcutaneous infusions; • Gastric tube or gastronomy feedings; • Nasopharygeal aspiration; • Insertion or replacement of catheters • Application of dressings involving prescribed medications; • Treatment of extensive decubiti; • Administration of medical gases 	<p>adaptive development. Developmentally delayed infants and toddlers are those who are determined to have a significant difference between the expected level of development for their age and their current level of functioning. This determination shall be made by qualified personnel who are recognized by, or part of, a multidisciplinary team, including the parents. A significant difference is defined as a 33-percent delay in one developmental area before 24 months of age, or, at 24 months of age or older, either a delay of 50 percent in one developmental area or a 33-percent delay in two or more developmental areas.</p> <p>2) Infants and toddlers with established risk conditions, who are infants and toddlers with conditions of known etiology or conditions with established harmful developmental consequences. The conditions shall be diagnosed by a qualified personnel recognized by, or part of, a multidisciplinary team, including the parents. The condition shall be certified as having a high</p>	<p>procedures such as, but not limited to, the following:</p> <ul style="list-style-type: none"> • Nursing assessment of the individuals' condition and skilled intervention when indicated; • Administration of injections and intravenous of subcutaneous infusions; • Gastric tube or gastronomy feedings; • Nasopharygeal aspiration; • Insertion or replacement of catheters • Application of dressings involving prescribed medications; • Treatment of extensive decubiti; • Administration of medical gases

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State Plan HCBS Needs-based eligibility criteria	NF	ICF/MR LOC	Hospitalization LOC
probability of leading to developmental delay if the delay is not evident at the time of diagnosis.		probability of leading to developmental delay if the delay is not evident at the time of diagnosis.	

6. **Reevaluation Schedule.** The State assures that needs-based reevaluations are conducted at least annually.
7. **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).
8. **Residence in home or community.** The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not an institution. *(Specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS, if applicable. Describe the criteria by which the State determines that these settings are not institutional in character such as privacy and unscheduled access to food, activities, visitors, and community pursuits outside the facility):*

N/A

Person-Centered Planning & Service Delivery

1. The State assures that there is an independent assessment of individuals determined to be eligible for HCBS. The assessment is based on:
 - An objective face-to-face evaluation by a trained independent agent;
 - Consultation with the individual and others as appropriate;
 - An examination of the individual's relevant history, medical records, care and support needs, and preferences;
 - Objective evaluation of the inability to perform, or need for significant assistance to perform 2 or more ADLs (as defined in § 7702B(c)(2)(B) of the Internal Revenue Code of 1986); and
 - Where applicable, an evaluation of the support needs of the individual (or the individual's representative) to participant-direct.
2. The State assures that, based on the independent assessment, the individualized plan of care:
 - Is developed by a person-centered process in consultation with the individual, the individual's treating physician, health care or supporting professional, or other appropriate individuals, as defined by the State, and where appropriate the individual's family, caregiver, or representative;
 - Identifies the necessary HCBS to be furnished to the individual, (or, funded for the individual, if the individual elects to participant-direct the purchase of such services);
 - Takes into account the extent of, and need for, any family or other supports for the individual;
 - Prevents the provision of unnecessary or inappropriate services/supports;
 - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and

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- Is reviewed at least annually and as needed when there is significant change in the individual's circumstances.

3. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.

There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. (*Specify qualifications*):

The minimum requirement is a degree in social sciences or a related field. Case management experience in the developmental disabilities field or a related field may be substituted for education on a year-for-year basis.

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

The minimum requirement is a degree in social sciences or a related field. Case management experience in the developmental disabilities field or a related field may be substituted for education on a year-for-year basis.

5. Supporting the Participant in Service Plan Development. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the 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*):

The service plan, commonly referred to as the individual family service plan (IFSP), is prepared by a team of participants that includes at minimum the parent of the infant or toddler, the case manager responsible for implementation of the IFSP and the person(s) who conducted the evaluations or assessments. When requested by the parent, IFSP development also may include other family members, advocates or others outside the family.

The IFSP is developed through a person-centered process of the infant's or toddler's developmental needs as well as the needs of the family related to meeting the developmental needs of the infant or toddler. Person-centered planning is an approach to determining, planning for, and working toward the preferred future of the infant or toddler and her or his family. Written consent from the parent must be obtained prior to the provision of any services described in the IFSP.

a) supports and information made available – Information available for supporting families in the IFSP process includes but is not limited to the following:

1. "Parents Rights: An Early Start Guide for Families" – This booklet, designed for parents and other interested persons, includes information regarding the IFSP development and review process, as well as the parent's rights during the development and implementation of the IFSP.

2. "Starting Out Together – An early Intervention Guide for Families" - This booklet outlines the in easily understandable language the IFSP process. Included in this discussion is the focus on the parent as the expert regarding their infant or toddler and therefore is a central figure in developing a working plan.

b) The participant's authority to determine who is included in the process – As noted above, in addition to the required participants in the IFSP process, the parents may request that others be involved including other family members, advocates or friends.

6. **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 service plan):

The case manager informs the parent of qualified providers of services determined necessary through the IFSP process. Parents may meet with qualified providers prior to the final decision regarding providers to be identified in the IFSP.

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

On a triennial basis, DHCS and DDS will review a representative sample of recipient IFSPs to ensure all service plan requirements have been met.

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

<input type="checkbox"/>	Medicaid agency	<input type="checkbox"/>	Operating agency	<input type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other (specify):	Regional centers are required to maintain service plans for a minimum of five years.			

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:	Infant Development Program		
Service Definition (Scope):			
This is a day training and activity program where infants and their families are provided training individually and in groups for a day or less, and are provided an organized program of activity. These programs are designed to encourage the development and adjustment of the infants in the community and their homes, and to prepare the infants for entrance into classes of local schools or other appropriate facilities.			
Additional needs-based criteria for receiving the service, if applicable (specify):			
Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):			
<input type="checkbox"/>	Categorically needy (specify limits):		
<input type="checkbox"/>	Medically needy (specify limits):		
Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Infant	Health and	N/A	Requires written program design,

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Development Program	Safety Code §1500-1567.8 Welfare and Institutions Code §4693		recipient entrance and exit criteria, staff training, etc. Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience in a human services delivery system, including at least one year in a comparable program or a bachelor's degree in child development, early childhood education, developmental disability education, or a closely related child-focused specialty.
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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):
Infant Development Program	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Infant Development Program	Department of Social Services – Community Care Licensing Division (DSS-CCLD)	Annually

Service Delivery Method. (Check each that applies):

<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
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2. Policies Concerning Payment for State Plan HCBS Furnished by Legally Responsible Individuals, Other Relatives and Legal Guardians. (Select one):

<input type="radio"/> The State does not make payment to legally responsible individuals, other relatives or legal guardians for furnishing state plan HCBS.
<input checked="" type="radio"/> The State makes payment to (check each that applies):

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<input type="checkbox"/>	<p>Legally Responsible Individuals. The State makes payment to legally responsible individuals under specific circumstances and only when the relative is qualified to furnish services. <i>(Specify (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) in cases where legally responsible individuals are permitted to furnish personal care or similar services, the State must assure and describe its policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual); (c) how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the State's strategies for ongoing monitoring of the provision of services by legally responsible individuals; and, (e) the controls that are employed to ensure that payments are made only for services rendered):</i></p>
<input checked="" type="checkbox"/>	<p>Relatives. The State makes payment to relatives under specific circumstances and only when the relative is qualified to furnish services. <i>(Specify: (a) the types of relatives who may be paid to furnish such services, and the services they may provide, (b) the specific circumstances under which payment is made; (c) the State's strategies for ongoing monitoring of the provision of services by relatives, and; (d) the controls that are employed to ensure that payments are made only for services rendered):</i></p> <p>Any of the services identified in the 1915(i) section of the State Plan may be provided by a recipient's relative if the relative meets all specified provider qualifications. The selection of the relative as a provider will only be done pursuant to applicable law and the assessment and person centered planning process. Regional centers will monitor, with DHCS and DDS oversight and monitoring, service provision and payment.</p>
<input checked="" type="checkbox"/>	<p>Legal Guardians. The State makes payment to legal guardians under specific circumstances and only when the guardian is qualified to furnish services. <i>(Specify: (a) the types of services for which payment may be made, (b) the specific circumstances under which payment is made; (c) the State's strategies for ongoing monitoring of the provision of services by legal guardians, and; (d) the controls that are employed to ensure that payments are made only for services rendered):</i></p> <p>Any of the services identified in the 1915(i) section of the State Plan may be provided by a recipient's legal guardian if the legal guardian meets all specified provider qualifications. The selection of the legal guardian as a provider will only be done pursuant to applicable law and the assessment and person centered planning process. Regional centers will monitor, with DHCS and DDS oversight and monitoring, service provision and payment.</p>
<input type="checkbox"/>	<p>Other policy. <i>(Specify):</i></p>

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):*

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<input checked="" type="radio"/>	The State does not offer opportunity for participant-direction of state plan HCBS.
<input type="radio"/>	Every participant in HCBS state plan services (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.
<input type="radio"/>	Participants in HCBS state plan services (or the participant’s representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. <i>(Specify criteria):</i>

2. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the HCBS State Plan option, 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):*

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

Participant-Directed Service	Employer Authority	Budget Authority
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

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

<input type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="radio"/>	Financial Management is furnished as an administrative function.

5. **Participant-Directed Service Plan.** The State assures that, based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Is directed by the individual or authorized representative and builds upon the individual’s preferences and capacity to engage in activities that promote community life;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual or representative;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques.

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

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7. **Opportunities for Participant-Direction**

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

<input type="radio"/>	The State does not offer opportunity for participant-employer authority.
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<input type="radio"/>	Participants may elect participant-employer Authority (<i>Check each that applies</i>):
<input type="checkbox"/>	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.
<input type="checkbox"/>	Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

<input type="radio"/>	The State does not offer opportunity for participants to direct a budget.
<input type="radio"/>	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. (<i>Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care</i>):
	Expenditure Safeguards. (<i>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</i>):

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Quality Management Strategy

(Describe the State's quality management strategy in the table below):

Requirement	Monitoring Activity (What)	Monitoring Responsibilities (Who)	Evidence (Data Elements)	Management Reports (Yes/No)	Frequency (Mos/Yrs)
Service plans address assessed needs of enrolled participants, are updated annually, and document choice of services and providers.	1. A representative sample of IFSPs will be reviewed to ensure all requirements are met. Sample size will depend on total number of recipients. The random sample will represent a 95% confidence level with no more than a 5% margin of error.	1. DHCS, DDS	1. The representative sample of IFSPs will be reviewed to determine that: all assessed needs are addressed; all services received and responsible providers are identified in the IFSP and agreed to by the individual; and the IFSP is reviewed at least semi-annually and revised when needed	1. Yes. Plans to correct all identified deficiencies will be included in final reports. Compliance will be tracked over time to identify trends that may require further intervention.	1. Triennially
	2. All recipients' IFSPs reviewed at least semi-annually and modified as needed based on each individual's needs.	2. Regional centers	2. Documentation in each individual's record of an (at least) semi-annual IFSP review or completion of a new IFSP.		2. Semi-annually
Providers meet required qualifications	1. Vendorization by the regional center in	1. Regional centers	1. Provider files maintained at		1. Upon application for

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Requirement	Monitoring Activity (What)	Monitoring Responsibilities (Who)	Evidence (Data Elements)	Management Reports (Yes/No)	Frequency (Mos/Yrs)
	<p>accordance with Title 17, CCR, §§ 54310 and 54326</p> <p>2. Licensing Evaluation by DSS-CCLD.</p>	2. DSS-CCLD	<p>regional center contain, as required: license; certification; program design; and staff qualifications.</p> <p>2. Facilities Automated System tracks annual visit dates. All facilities are reviewed annually to determine compliance with regulations regarding provision of services, health and safety and provider qualifications.</p>	2. Yes. Evaluation reports identify any deficiencies identified.	<p>vendorization and ongoing thereafter through oversight and monitoring activities.</p> <p>2. Annually</p>
The SMA retains authority and responsibility for program operations and oversight.	1. DHCS participation in IFSP reviews as described in “service plan” requirement above.	DHCS	<p>1. Results (described in “service plan” requirement above) of sample IFSP reviews.</p> <p>2. IA approval based</p>		<p>1. Triennially</p> <p>2. As required</p>

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Requirement	Monitoring Activity (What)	Monitoring Responsibilities (Who)	Evidence (Data Elements)	Management Reports (Yes/No)	Frequency (Mos/Yrs)
	<p>2. Review, negotiate and approve amendment requests for the interagency agreement (IA).</p> <p>3. Review 1915(i) related policies, procedures, and regulations that are developed by and received from DDS.</p>		<p>on compliance with applicable state and federal laws, regulations and policies.</p> <p>3. Documentation of policy and/or procedure review to ensure compliance with applicable state and federal laws, regulations and policies.</p>		3. As required
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to enrolled participants by qualified providers.	<p>1. Fiscal audits of regional centers conducted by DDS.</p> <p>2. Vendor audits conducted by DDS and regional centers.</p>	<p>1. DHCS staff review working papers prepared by DDS audit staff of regional centers on a sample basis.</p> <p>2. DHCS conducts, on an annual basis, a random sample review of the</p>	<p>1. Regional center audit reports identify any fiscal compliance issues with state or federal laws, regulations or policies.</p> <p>2. Vendor audit reports.</p>	<p>1. Yes. Regional center audit reports include all deficiencies identified and the regional center plans to address the deficiencies.</p> <p>2. Yes. Vendor audit reports include any deficiencies identified and actions</p>	<p>1. Biennially</p> <p>2. Ongoing</p>

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Requirement	Monitoring Activity (What)	Monitoring Responsibilities (Who)	Evidence (Data Elements)	Management Reports (Yes/No)	Frequency (Mos/Yrs)
	3. Review of Independent CPA regional center audits. DDS fiscal audits are designed to wrap around the independent CPA audit to ensure comprehensive financial accountability.	regional center vendor audit reports. 3. DHCS, DDS	3. Independent CPA audit reports. Independent audits are conducted annually at each regional center	needed to address to address the deficiencies.	3. Annually
	4. Verification of recipient eligibility for Medi-Cal	4. DHCS, DDS, Regional Centers	4. Medi-Cal eligibility match, invoice reports.	4. Yes.	4. Monthly
	5. Invoice tracking, payment and reconciliation processes.	5. DHCS	5. Tracking logs verify consistency between payments and invoices.		5. Monthly
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	1. IFSPs are developed that address all recipient needs, including	1. DHCS, DDS, Regional centers	1. Results (described in "service plan" requirement above) of sample IFSP	1. Yes. Plans to correct all identified deficiencies will be included in final	1. Triennially

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Requirement	Monitoring Activity (What)	Monitoring Responsibilities (Who)	Evidence (Data Elements)	Management Reports (Yes/No)	Frequency (Mos/Yrs)
	health and welfare. 2. Review of special incident reports (SIRs) 3. Review and analysis of SIR data to identify trends.	2. DDS, regional centers 3. DDS, independent risk management contractor	reviews. 2. Incident reports identify appropriate follow-up is taken, including measures to prevent reoccurrence if possible. 3. DDS and risk management contractor reports. Technical assistance and/or information provided as a result of the analysis. Summary of risk management activities sent to DHCS.	reports. Compliance will be tracked over time to identify trends that may require further intervention. 2. Yes. Reports are run from the SIR database system to identify issues requiring further analysis and follow-up. 3. Yes. DDS and risk management contractor reports.	2. Regional centers review all SIRs daily. DDS reviews a sample of SIRs daily. 3. On-going
Describe the process(es) for remediation and systems	The following describes State's quality management framework which starts with establishing clear expectations for performance (design), collecting and analyzing data to determine if the expectations are met				

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improvement.	<p>(discovery), and finally, taking steps to correct deficiencies or improve processes and services (remediation and improvement).</p> <p>Service Plans or individual family service plans (IFSPs)</p> <p>Performance expectations (design) in this area include:</p> <ul style="list-style-type: none"> • Service plans must address all participants’ assessed needs (including health and safety risk factors) and personal goals. • Service plans are reviewed at least semi-annually and updated/revised when warranted by changes in the participant’s needs. • Services are delivered in the type, scope, amount, duration, and frequency in accordance with the service plan. • Participants are afforded choice of qualified providers. <p>Data collected (discovery) to determine if expectations are met includes:</p> <ul style="list-style-type: none"> • DHCS and DDS conduct triennial monitoring reviews of a random, representative sample of service recipient records to ensure service plans meet the expectations identified above. Monitoring will be completed over a three year period with reports produced after reviewing each geographical region (regional center). The statewide sample size will produce results with a 95% confidence level and no more than 5% margin of error. For example, with an estimated 4,000 recipients, the sample size would be 351. • Annually, all recipients receive a statement of services and supports purchased by the regional center for the purpose of determining if services were delivered. <p>Steps to correct deficiencies or improve processes and services (remediation and improvement) include:</p> <ul style="list-style-type: none"> • Regional centers are required to submit plans to correct all issues identified in the triennial monitoring 				

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	<p>conducted by DHCS and DDS. These plans are reviewed and approved by the State.</p> <ul style="list-style-type: none"> • The data from the monitoring reviews allows for identification of trends in a particular area (e.g. specific requirement or geographical area). • If any of the monitoring reviews result in a significant level of compliance issues, a follow-up review will be scheduled to evaluate the progress of the corrective actions taken in response to the previous monitoring review. • Extra training and/or monitoring is provided on identified issues. • DDS' Quality Management Executive Committee (QMEC), also attended by DHCS management, meets quarterly to review data regarding service recipients, explore issues or concerns that may require intervention, and develop strategies and/or interventions for improved outcomes. <p>Qualified Providers</p> <p>Performance expectations (design) in this area include:</p> <ul style="list-style-type: none"> • DDS sets qualifications for providers through the regulatory process. • Regional centers, through the vendorization process, verify that each provider meets the required qualifications (e.g. license, program design, staff qualifications) prior to services being rendered. • DSS-CCLD is responsible for licensing providers and establishes qualifications for providers. <p>Data collected (discovery) to determine if expectations are met includes:</p> <ul style="list-style-type: none"> • DSS-CCLD monitors all licensed providers to identify compliance issues. Facilities are reviewed to determine compliance with regulations regarding provision of services, health and safety and provider qualifications. • Special incident report data allows for identification of trends with individual providers or types of providers. 				

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	<p>Steps to correct deficiencies or improve processes and services (remediation and improvement) include:</p> <ul style="list-style-type: none"> • Any DSS-CCLD monitoring visit that results in a finding of non-compliance results in the development of a plan of correction. This requires follow-up by DSS-CCLD staff to verify that corrections were made. • Data from the special incident report system is used to identify trends with individual or types of providers which may then result in focused or widespread training or other remediation measures. • DDS' Quality Management Executive Committee (QMEC), also attended by DHCS management, meets quarterly to review data regarding service recipients, explore issues or concerns that may require intervention, and develop strategies and/or interventions for improved outcomes. As an example, data from the special incident report system and analysis by the State's independent risk management indicated that the second largest cause of unplanned hospitalizations was due to psychiatric admissions. In response, the QMEC approved the implementation of skill checks within challenge tests. The skill checks now require staff to demonstrate proficiency in the proper method of assisting individuals in the self-administration of medications. <p>SMA Programmatic Authority</p> <p>Performance expectations (design) in this area include:</p> <ul style="list-style-type: none"> • DHCS reviews and approves reports developed as a result of programmatic monitoring. • DHCS negotiates approval and amendment requests for the interagency agreement with DDS to ensure consistency with federal requirements. • DHCS approves Section 1915(i) related policies, procedures and regulations that are developed by DDS to ensure consistency with federal requirements. • DHCS participates, as necessary, in training to regional centers and providers regarding Section 1915(i) policies and procedures. 				

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	<ul style="list-style-type: none"> DHCS participates in the quarterly DDS Quality Management Executive Committee. The purpose of these meetings is to review data regarding service recipients, explore issues or concerns that may require intervention, and develop strategies and/or interventions for improved outcomes. <p>Data collected (discovery) to determine if expectations are met includes:</p> <ul style="list-style-type: none"> Results from the triennial monitoring reviews, conducted by DHCS and DDS, of a random, representative sample of service recipient records to ensure service plans meet the expectations identified previously. Documentation of DHCS approval of monitoring or other required reports. Monitoring reports will also include approved plans submitted in response to findings by DHCS and DDS. Minutes from meetings DHCS participates in documenting issues discussed and resolution activities planned. <p>Steps to correct deficiencies or improve processes and services (remediation and improvement) include:</p> <ul style="list-style-type: none"> Regional centers are required to submit plans to correct all issues identified in the triennial monitoring conducted by DHCS and DDS. These plans are reviewed and approved by the State. If any of the monitoring reviews result in a significant level of compliance issues, a follow-up review will be scheduled to evaluate the progress of the corrective actions taken in response to the previous monitoring review. Extra training and/or monitoring is provided on identified issues. <p>SMA Maintains Financial Accountability</p> <p>Performance expectations (design) in this area include:</p> <ul style="list-style-type: none"> DHCS reviews a sample of working papers prepared by DDS audit staff of the biennial fiscal audits. These fiscal audits are designed to wrap around the required annual independent CPA audit of each regional 				

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	<p>center.</p> <ul style="list-style-type: none"> • DHCS also annually reviews a sample of audits conducted of service providers. • DHCS ensures recipients are eligible for Medi-Cal prior to claims being made. • DHCS maintains invoice tracking, payment and reconciliation processes. <p>Data collected (discovery) to determine if expectations are met includes:</p> <ul style="list-style-type: none"> • Results of the audit reviews identify fiscal compliance issues. • Electronic records and hard copy reports (as needed) are generated identifying recipients eligible for claiming. • Tracking logs verify consistency between invoices, payments and funding authority. <p>Steps to correct deficiencies or improve processes and services (remediation and improvement) include:</p> <ul style="list-style-type: none"> • DHCS monitors and provides consultation as necessary regarding corrective actions and follow-up activities resulting from regional center and vendor audits. All issues identified in the audits include corrective action plans which may include policy revisions or repayments if necessary. • DHCS works with DDS to resolve issues, if any, with identifying Medi-Cal eligibility of recipients. <p>Risk Mitigation</p> <p>Performance expectations (design) in this area include:</p> <ul style="list-style-type: none"> • Service plans must address all participants’ assessed needs (including health and safety risk factors) and personal goals. • DDS, through the regulatory process, has identified requirements for service providers and regional centers regarding reporting of special incidents. Providers must report all special incidents to the regional center within 24 hours. Subsequently, regional centers must report special incidents to DDS within two working 				

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Requirement	Monitoring Activity <i>(What)</i>	Monitoring Responsibilities <i>(Who)</i>	Evidence <i>(Data Elements)</i>	Management Reports <i>(Yes/No)</i>	Frequency <i>(Mos/Yrs)</i>
	<p>days.</p> <ul style="list-style-type: none"> • DDS has implemented an automated special incident report (SIR) system and database which allows complex analysis of multiple factors to identify trends and provide feedback to regional centers. • DDS provides data from the SIR system to the State’s independent risk management contractor for further analysis. • Regional centers must transmit SIRs, including the outcomes and preventative actions taken, to DDS as well as local licensing offices and investigative agencies as appropriate. • Regional centers must develop and implement a risk management and prevention plan. • Regional centers are responsible for using data from the SIR system for identifying trends that require follow-up. • The State’s risk management contractor is responsible for reviewing and analyzing DDS SIR data to identify statewide, regional and local trends requiring action. This includes defining indicators of problems requiring further inquiry. Additionally, the contractor performs ongoing review and analysis of the research and current literature with respect to preventing accidents, injuries and other adverse incidents. <p>Data collected (discovery) to determine if expectations are met includes:</p> <ul style="list-style-type: none"> • DDS and DHCS conduct triennial monitoring reviews of a random, representative sample of service recipient records to ensure service plans address health and safety risk factors. • Data from the SIR system includes recipient characteristics, risk factors, residence, responsible service provider and other relevant information. This data is updated daily and is available not only to DDS but also to regional centers for reviewing data of incidents in their area. <p>Steps to correct deficiencies or improve processes and services (remediation and improvement) include:</p> <ul style="list-style-type: none"> • Regional centers are required to submit plans to correct all issues identified in the triennial monitoring conducted by DHCS and DDS. These plans are reviewed and approved by the State. • If any of the monitoring reviews result in a significant level of compliance issues, a follow-up review will 				

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	<p>be scheduled to evaluate the progress of the corrective actions taken in response to the previous monitoring review.</p> <ul style="list-style-type: none"> • Extra training and/or monitoring is provided on identified issues. • DDS uses data from the SIR system to identify compliance issues such as reporting timelines and notifications of other agencies if required. Contact is made with regional centers for correction. Training or technical assistance is provided if necessary. • Utilizing results of data analysis from the SIR system, the State’s risk management contractor conducts a variety of activities, including: develop and disseminate periodic reports and materials on best practices related to protecting and promoting the health, safety, and well-being of service recipients; provide on-site technical assistance to regional centers related to local risk management plans and activities; define indicators requiring further inquiry. • The risk management contractor also develops and maintains a website, (www.ddssafety.net) for recipients and their families, providers, professionals, and regional center staff. This website is dedicated to the dissemination of information on the prevention and mitigation of risk factors for persons with developmental disabilities. The site includes information from across the nation on current research and best practices and practical information directed towards improving health and safety. 				

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):*

See attachment 4.19-B for descriptions of the rate setting methodologies for the services identified below.

<input type="checkbox"/>	Habilitation – Community Living Arrangement Services
<input type="checkbox"/>	Habilitation - Day Services
<input type="checkbox"/>	Habilitation – Behavioral Intervention Services
<input type="checkbox"/>	Respite Care
<input type="checkbox"/>	Personal Care Services
<input type="checkbox"/>	Homemaker
<input type="checkbox"/>	Home Health Aide
<input type="checkbox"/>	Adult Day Health Care
<input checked="" type="checkbox"/>	Other Services
<input checked="" type="checkbox"/>	Infant Development Program

- 2. Presumptive Eligibility for Assessment and Initial HCBS.** Period of presumptive payment for HCBS assessment and initial services, as defined by 1915(i)(1)(J) *(Select one):*

<input checked="" type="radio"/>	The State does not elect to provide for a period of presumptive payment for individuals that the State has reason to believe may be eligible for HCBS.
<input type="radio"/>	The State elects to provide for a period of presumptive payment for independent evaluation, assessment, and initial HCBS. Presumptive payment is available only for individuals covered by Medicaid that the State has reason to believe may be eligible for HCBS, and only during the period while eligibility for HCBS is being determined. The presumptive period will be <input type="text"/> days (not to exceed 60 days).

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