

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

JUL 31 2013

Toby Douglas, Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Mr. Douglas:

Enclosed is an approved copy of California State Plan Amendment (SPA) 13-007. SPA 13-007 was submitted to my office on May 3, 2013 to update the eligibility language related to Medi-Cal's Community First Choice Option (CFCO) to comply with Section 1915(k)(1) of the Social Security Act. Additionally, this SPA enhances the quality assurance provisions related to Medi-Cal's CFCO.

The effective date of this SPA is July 1, 2013. Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- Attachment 3.1-k, pages 1, 1a, 5, 8, 9, 13, 14, 17, 21 & 22

If you have any questions, please contact Tom Schenck by phone at (415) 744-3589 or by email at tom.schenck@cms.hhs.gov.

Sincerely,

A handwritten signature in cursive script that reads "Gloria Nagle".

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Kathyryn Waje, California Department of Health Care Services
Betsi Howard, California Department of Health Care Services

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Sincerely,

ORIGINAL DOCUMENT SIGNED BY :

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

Cc: Kathryn Waje, California Department of Health Care Services
Betsi Howard, California Department of Health Care Services

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 13-007	2. STATE California
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION		4. PROPOSED EFFECTIVE DATE July 1, 2013
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

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

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION: 1915(k) 42 CFR part 441	7. FEDERAL BUDGET IMPACT: a. FFY 2013 \$ 0 b. FFY 2014 \$ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: CMS revised pages: Attachment 3.1-K, Pages 1, 1a, 5, 8, 9, 13, 14, 17, 21 and 22	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): CMS revised pages: Attachment 3.1-K, Pages 1, 1a, 5, 8, 9, 13, 14, 17, 21 and 22

10. SUBJECT OF AMENDMENT:

Community First Choice Option

11. GOVERNOR'S REVIEW (*Check One*):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED The Governor's Office does not
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL: Original document signed by:	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
13. TYPED NAME: Toby Douglas	
14. TITLE: Director	
15. DATE SUBMITTED: May 3, 2013	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: CMS dated May 3, 2013	18. DATE APPROVED: CMS approved on July 31, 2013
PLAN APPROVED – ONE COPY ATTACHED	

19. EFFECTIVE DATE OF APPROVED MATERIAL: CMS dated 7/1/2013	20. SIGNATURE OF REGIONAL OFFICIAL: Original document signed by Gloria Nagle
21. TYPED NAME: Gloria Nagle, PhD, MPA	22. TITLE:

23. REMARKS:
Pen and ink changes boxes 7, 8 and 9

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Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

i. Eligibility

The State determines eligibility for CFCO services in the manner as prescribed in Social Security Act §1915(k)(1) and 42 CFR section 441.510. Effective on July 1, 2013, to receive CFCO, an individual must meet the following requirements:

- (a) Be eligible for medical assistance under the State plan;
- (b) As determined annually—
 - (1) Be in an eligibility group under the State plan that includes nursing facility services; or
 - (2) If in an eligibility group under the State plan that does not include such nursing facility services, have an income that is at or below 150 percent of the Federal poverty level (FPL). In determining whether the 150 percent of the FPL requirement is met, the State must apply the same methodologies as would apply under the Medicaid State plan, including the same income disregards in accordance with section 1902(r)(2) of the Act; and,
- (c) Receive a determination, at least annually, that in the absence of the home and community-based attendant services and supports provided under this subpart, the individual would otherwise require the level of care furnished in a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the State plan.
- (d) For purposes of meeting the criterion under paragraph (b) of this section, individuals who qualify for medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must meet all section 1915(c) requirements and receive at least one home and community-based waiver service per month.

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ii. **Service Delivery Models**

- Agency Model - The Agency Model is based on the person-centered assessment of need. The Agency Model is a delivery method in which the services and supports are provided by entities under a contract.
- Self-Directed Model with service budget – This Model is one in which the individual has both a service plan and service budget based on the person-centered assessment of need.
- Direct Cash
- Vouchers
- Financial Management Services in accordance with 441.545(b)(1).

Provider qualifications for the self-directed model are designed to ensure necessary safeguards have been taken to protect the health and welfare of participants, including criminal background checks (including finger printing) and an orientation designed to ensure providers are capable of safely providing required services.

Providers convicted of fraud are excluded under the federal regulations as specified in 42 CFR section 1001.101 and those convicted of elder and specified child abuse are also excluded as allowed under federal law pursuant to 42 CFR 1002.2. The recipient may hire their provider of choice regardless of any other felony convictions utilizing the statutory waiver process where applicable.

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- This permissible service will be limited to those participants choosing the Restaurant Meal Allowance (RMA). Permissible Purchases are allowed for the purchase of prepared meal services for individuals with an assessed need for meal preparation, meal clean-up and shopping for food. Permissible purchases are in lieu of meal preparation, meal clean-up and shopping for food. See section xii. Permissible Purchases for details.
2. Expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for individuals with intellectual disabilities to a community-based home setting where the individual resides.
- C. County social workers will perform the following Support System Service activities:
- appropriately assess an individual's service needs before enrollment;
 - provide appropriate information, training and assistance to ensure an individual is able to manage the services and budgets;
 - communicate information to the individual in a manner and language that is understandable by the individual;
 - provide person-centered planning;
 - provide a process for changing the person-centered service plan/budget
 - provide information on the grievance process;
 - review the risks and responsibilities of self-direction;
 - have the ability to choose freely from available home and community-based attendant providers;
 - identify and access services, supports, and resources;
 - develop a risk management agreement and a personalized back-up plan;
 - recognize and report critical incidents; and
 - make information available on advocates or advocacy systems.
- i. Use of Direct Cash Payments**
- A. X The State elects to disburse cash prospectively to CFCO participants. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.
- Only for participants receiving the following options:
- Restaurant Meal Allowance (please see Permissible Purchases, section xii.); and

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- (H) The State assures that home and community-based attendant services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws.
- (I) The State assures it established a Development and Implementation Council prior to submitting a State Plan Amendment in accordance with section 1915(k)(3)(A). The council is primarily comprised of consumers who are individuals with disabilities, elderly individuals and their representatives.

vii. Service Plan

The State shall make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing:

- (i) under a person-centered plan of services and supports that is based on an assessment of functional need and that is fully disclosed in writing and agreed to by the participant, or as appropriate, their representative;

Assessments of need are conducted by county social workers every 12 months or as needed when the individual's support needs or circumstances change, or at the request of the individual or the individual's representative.

County social workers facilitate and monitor the person-centered plan during initial assessments and annual reassessments, or as needed when the individual's support needs or circumstances change, or at the request of the individual or the individual's representative.

- (ii) CFCO Services will be provided in a home or community setting, which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for individuals with intellectual disabilities. CFCO services are available and provided to individuals residing in settings that meet the federal regulatory requirements for a home and community-based setting and include, but are not limited to, single-family homes, duplexes, apartments, congregate independent living communities, and settings which provide room and board.
- (iii) under an agency-provider model or other model; and

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- (iv) the furnishing of which:
- (I) is provided by a provider who is selected, managed, and dismissed by the individual, or, as appropriate, with assistance from the individual's representative;
 - (II) is controlled, to the maximum extent possible, by the individual or where appropriate, the individual's representative, regardless of who may act as the employer of record; and
 - (III) is provided by an individual who is qualified to provide such services, including family members.
- (v) Where applicable, CFCO Services will be provided consistent with the manner authorized in Article 7 (commencing with Section 12300) of Chapter 3 for the In-Home Supportive Services program.

viii. Quality Assurance and Improvement Plan

The State's quality assurance and improvement plan is described below. It includes components for the 58 counties and for the California Department of Social Services (CDSS) in consultation with the Department of Health Care Services (DHCS). Both components must address:

- i. Activities of discovery, remediation, and quality improvement, to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and
- ii. The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.

The following describes the system-wide quality assurance and improvement plan CDSS, in conjunction with the 58 counties, has that includes the activities of discovery, remediation and quality improvement. This plan will help to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement to ensure the health and welfare of our CFCO participants.

County

Each of the 58 counties must create and submit to CDSS county-specific IHSS QA policies and procedures which are in compliance with federal, state and county policies. . County policy and procedures (P&P) must specify the processes for addressing discovery, remediation, and overall system improvement. The procedures must provide for reporting findings to program staff and supervisors for remediation and must include detailed procedures for discovery, remediation, and tracking of critical incidents. The procedures outlined in the P&P are designed to assure the timeliness and effectiveness of the county's' actions to protect

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participant health and welfare, and program integrity. Counties must also prepare and submit an annual quality assurance/quality improvement (QA/QI) plan that consists of an IHSS QA budget justification, an attestation from the program manager that county P&P is current, and a description of any aspect of IHSS QA that has changed from the previous year or differs from established P&P.

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Each county submits a completed Quarterly Report form (SOC 824) by e-mail to the CDSS QA Bureau covering the QA/QI activities conducted during the reporting quarter. The report includes the number of, and information gathered from, routine scheduled reviews, home visits, and targeted reviews. It also includes critical events/incidents identified, actions taken on critical events/incidents, and any system improvement efforts made as a result of issues identified during the quarter.

CDSS

The CDSS has two roles in the QA/QI Plan, as reviewer of county QA/QI plans and activities, and as conductor of its own QA/QI activities. These two functions are separate but often overlap, and together provide an additional layer of validation of quality assurance and program integrity.

CDSS Review of Counties QA/QI

The CDSS QA staff monitoring is accomplished by: reviewing county P&P, annual QA/QI Plans, and Quality Improvement Plans (QIAPs); reviewing, analyzing, aggregating and reporting on county Quarterly Reports; performing case reviews, including county QA reviewed files and denied applications; and observing county QA home visits.

Based on the findings from these reviews, CDSS helps counties by:

- Collaborating on the creation of county action plans;
- Collaborating on the development of new county P&P;
- Providing technical assistance in the development of annual QA/QI plans; and
- Providing training on specific issues to individual counties as well as statewide.

The goal of the CDSS review of county QA/QI activities is to ensure that initial assessments and reassessments are conducted in a timely and uniform manner, participant needs are correctly assessed, and the health, welfare, and quality of life of participants is maintained.

Discovery

As part of its discovery activities, CDSS carries out regularly scheduled county visits, during which the QA staff perform case file reviews and observe county QA staff conducting home visits. The CDSS QA monitoring staff conducts monitoring of the State's 58 counties annually.

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Prior to a site visit, CDSS QA reviews the county's P&P and annual QA/QI Plan, pulls data to analyze the county as compared to other counties. County performance is reviewed in the areas of:

- Timely reassessment compliance rate;
- Proportion of severely impaired recipients to total caseload;
- Average hours assessed per case;
- Average cost per case;
- IHSS staff participation in State-sponsored training; and
- Participation in recent data match and error rate study activities

At the county office, CDSS QA staff begin with an introduction, discussion of the county's P&P and annual QA/QI Plan, the comparison data (as described above), and an opportunity for county to discuss any issues that may impact the visit or the result of the review. The CDSS QA staff then review:

- A predetermined sample of case files for correct application of federal and State regulations and requirements, proper use of required documents, appropriate and well documented justification for services, appropriate and clearly documented reasons for exceptions to hourly task guidelines, and evidence that individualized risk planning has occurred;
- A sample of case files reviewed by county QA staff is evaluated for QA activities, the appropriateness of the forms, and any corrective actions taken;
- Appropriateness of denied and disenrolled cases to ensure that denial of likely cases and involuntary disenrollments from the program were appropriate;
- County policies and procedures for service registries and training available to providers and participants;
- Intake and enrollment procedures, including the participants' assessment/annual reassessment and level of assistance;
- Provider enrollment forms and qualifications; and
- Procedures for identification, remediation, and prevention of abuse.

During the county office segment of the site visit, CDSS QA staff review the case narratives to identify possible issues. These issues include provider problems, timesheet issues or questions related to the participant's assessment/reassessment needs. CDSS QA staff evaluate the issues

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- Required remedial actions in more than 30% cases reviewed by county QA

Outcome Measure 2 – CDSS *QA Improvement Action Plan Calculation
$\frac{\text{\# of counties with instituted QIAPs}}{\text{\# of counties with QIAPs}} = \% \text{ of county compliance}$

* This requirement is only in regards to counties who have a QIAP.

Satisfaction Measure 1: Customer Service Evaluation

Desired Outcome: Program participants are satisfied their in-home service and support needs are being met by the program, are able to contact the appropriate people when needed, and are able to satisfactorily self-direct their services.

QA Function: Appropriate questions are asked to participants regarding their satisfaction of the program, services and self-direction options. Upon completion of each survey, percentages will be calculated and reviewed. CDSS QA will then use this data to determine if changes in the program are needed.

The survey(s) will be comprehensive, results will be validated, and the tool will be administered by CDSS on a statewide basis. CDSS will use the results of the survey to generate a report, which will be disseminated to counties and posted on the CDSS website.

Data Collection Methods

Data collected for the performance measures (one through five) are obtained during the county and CDSS case reviews and home visits. County data are reported to CDSS in Quarterly Reports. CDSS data are collected throughout the year and included in the CDSS QA Monitoring Summary.

Sampling Approach

CDSS will work with counties to draw a random sample of a size determined by using the sample size calculator available on the Raosoft website, <http://www.raosoft.com/samplesize.html>. Standard parameters are assumed: Level of Confidence ranging from 90% to 97%, margin of error ranging from +/- 3% to +/- 6%. This approach will result in similar but different size samples in each county. The actual percentage of the statewide caseload that is sampled will depend on the distribution of caseloads by county. This approach will result in a sample that has an acceptable probability of being representative of the actual CFCO population..

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Frequency of Data Collection

Data collection takes place on an ongoing basis within each aspect of the program. Performance measure data will be finalized at the end of each State fiscal year and available upon request. Counties work throughout the year to meet their individual targets and goals to assure maximum review.

Roles and Responsibilities for Data Collection

County QA staff are responsible for gathering data in keeping with the criteria set forth in State and county P&P. QA staff are also responsible for maintaining this data.

Process for Tracking and Analyzing Collected Data

Roles and Responsibilities for Tracking and Analyzing Collected Data

Counties are responsible for tracking and analyzing data gathered during QA activities. Moreover, QA staff review online CMIPS data to identify program issues specific to that county. The methodology for tracking and analyzing these data can allow for ease in reporting on the SOC 824 form. County QA staff are responsible for assuring that the data are analyzed for trends and/or program shortfalls.

The CDSS QA staff are responsible for tracking and analyzing data reported quarterly by the counties and gathered during CDSS QA county monitoring visits. CDSS staff analyze online CMIPS data and data reported on the quarterly SOC 824 forms to identify program issues specific to a particular county or statewide.

i. Risk Management

A. The risk assessment methods used to identify potential risks to participants are described below.

During the intake and reassessment process:

1. The county social worker assesses participant's functional abilities in all activities of daily living utilizing the following process:
 - County social service staff determines the participant's level of ability and dependence upon verbal or physical assistance by another for each of the program functions.
 - This assessment process evaluates the effect of the participant's physical, cognitive and emotional impairment on functioning.
 - The county social service staff observes the participant in their own environment.