Application for a §1915 (c) HCBS Waiver
HCBS Waiver Application Version 3.3
Submitted by:
State of California Department of Health Services

Application for a §1915(c) Home and Community-Based Services Waiver

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Submitted by:

State of California **Department of Health Services**

Submission Date:	September 29, 2006; Revised Waiver resubmitted December 15, 2006

CMS Receipt Date *(CMS Use)***:**	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:
The California Department of Health Services (CDHS) is submitting a request for a new Home and Community-Based Services (HCBS) Waiver. The new waiver will be called the HCBS In-Home Operations (IHO) Waiver and will target Medi-Cal beneficiaries who 1) have continuously been enrolled in an IHO-administered HCBS waiver since prior to January 1, 2002, and have received and continue to receive direct care services primarily rendered by a licensed nurse or 2) have been receiving continuous care in an acute hospital for 36 months or greater, and have **primary care** physician-ordered direct care services that are in excess of the Nursing Facility and Acute Hospital (NF/AH) Waiver for the participant's assessed level of care (LOC). Participants enrolled in this waiver will meet the criteria for Nursing Facility – Distinct Part (NF/DP) or Nursing Facility Subacute (NF SA) inpatient placement. Participants currently enrolled in either the Nursing Facility A and B (NF A/B) Level of Care Waiver, Control Number 0139.90, or the NF Subacute (NF SA) Waiver, Control Number 0384.01, will be assessed for transition to the HCBS IHO Waiver. CDHS/IHO is proposing the implementation of the HCBS IHO Waiver to correspond with the Centers for Medicare & Medicaid Services (CMS)

approval of the HCBS NF /AH Waiver.

The HCBS IHO Waiver will offer the same services and providers previously approved by CMS for the NF A/B and NF SA waivers, but with the addition of habilitation and community transition services and **two new provider types:** non-profit agency **and In-Home Supportive Services (IHSS) Public Authority.**

Application for a §1915(c) Home and Community-Based Services Waiver

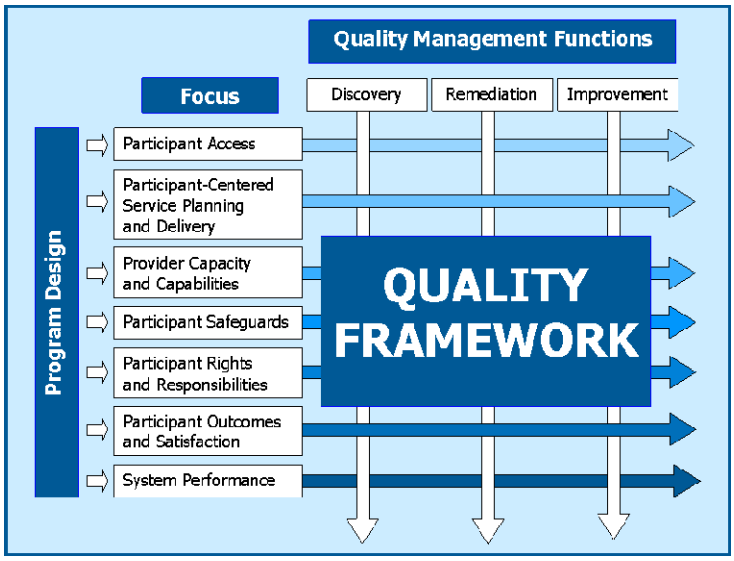
PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state, and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- **Participant Access**: *Individuals have access to home and community-based services and supports in their communities.*
- **Participant-Centered Service Planning and Delivery**: *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*
- **Provider Capacity and Capabilities**: *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- **Participant Safeguards**: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- **Participant Rights and Responsibilities**: *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- **Participant Outcomes and Satisfaction**: *Participants are satisfied with their services and achieve desired outcomes.*
- **System Performance**: *The system supports participants efficiently and effectively and constantly strives to improve*



quality.

The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework.

1. Request Information

A. The **State** of **California** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Waiver Title (*optional*): **Home and Community-Based Services (HCBS) In-Home Operations (IHO) Waiver**

C. Type of Request *(select only one)*:

X	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	**0457**
○	**New Waiver (3 Years) to Replace Waiver #**		
	CMS-Assigned Waiver Number (*CMS Use*):		
	Attachment #1 contains the transition plan to the new waiver.		
○	**Renewal (5 Years) of Waiver #**		
○	**Amendment to Waiver #**		

D. Type of Waiver *(select only one)*:

○	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
X	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: **January 1, 2007**

E.2 Approved Effective Date *(CMS Use)*:

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan :

○	Hospital *(select applicable level of care)*	
	○	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	○	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
X	Nursing Facility *(select applicable level of care)*	
	X	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
		NF D/P, NF-B Pediatric and Subacute LOC.
	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☐	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities *(check the applicable authority or authorities)*:

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

	Specify the §1915(b) authorities under which this program operates :			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program authorized under §1115 of the Act. *Specify the program:*			
X	Not applicable			

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the Home and Community-Based Services (HCBS) In-Home Operations (IHO) Waiver is to provide Medi-Cal beneficiaries who have been 1) have continuously been enrolled in an IHO-administered HCBS waiver since prior to January 1, 2002, and have received and continue to receive direct care services primarily rendered by a licensed nurse or 2) have been receiving continuous care in an acute hospital for 36 months or greater, and have **primary care** physician-ordered direct care services that are in excess of the Nursing Facility and Acute Hospital (NF/AH) Waiver for the participant's assessed level of care (LOC). The alternative to enrollment in this HCBS IHO Waiver is inpatient placement in a Nursing Facility – Distinct Part (NF/DP) or Nursing Facility Subacute (NF SA).

CDHS/IHO will transition currently enrolled NF A/B and NF SA Waiver eligible participants into the HCBS IHO Waiver without any disruption to his/her current services. These participants will continue to receive medically necessary services as ordered in the participant's **primary care** physician-signed Plan of Treatment (POT) that is in effect on the date of the participant's enrollment in the HCBS IHO Waiver. Participants identified as meeting the criteria set forth in the HCBS IHO Waiver will receive a written transition letter advising them of CDHS/IHO's decision to transition them to the HCBS IHO Waiver, effective the date CMS authorizes implementation of the HCBS IHO Waiver.

All participants of the NF A/B and NF SA waivers will be assessed for transition to either the HCBS Nursing Facility/Acute Hospital (NF AH) Waiver or the HCBS IHO Waiver. Participants refusing transition to the either waiver will be sent a Notice of Action (NOA), informing them of their ineligibility to receive CDHS/IHO-authorized HCBS waiver services. A~~n~~ CDHS/IHO Nurse Evaluator (NE) will be responsible for assisting the waiver participant declining transition to the HCBS IHO Waiver in obtaining appropriate nursing facility placement or providing the participant with information on other resources available within the community, including information on how to access other available HCBS waivers and/or State plan services.

Medi-Cal beneficiaries meeting the 36-month continuous acute hospital care criteria will be assessed to determine if they meet this waiver's eligibility criteria.

Waiver Year 1, Factor C cap is set at 210 persons, with no more than 210 waiver

participants receiving services at one time.

Waiver cost neutrality is calculated in the aggregate, and does not exceed the cost of providing NF/DP or NF SA inpatient facility services. Upon transition to the HCBS IHO Waiver, currently enrolled NF A/B and NF SA Waiver participants are eligible to receive the same type, amount, and frequency of waiver and State plan services as they received through the NF A/B or NF SA waivers. Participants enrolled under the 36-month continuous acute hospitalization criteria are eligible to receive the type, amount and frequency of waiver and State plan services as ordered by their **primary care** physician to ensure the participant's health and safety. Utilization of waiver and State plan services are monitored by the use of the CDHS/IHO Menu of Health Services (MOHS). The MOHS lists all HCBS IHO Waiver services and documents the amount of services the participant has been authorized to receive.

The CDHS/IHO Section is responsible for the implementation and monitoring of the proposed HCBS IHO Waiver. Organizationally, CDHS/IHO has two regional offices. The northern and southern California regional offices are responsible for conducting the initial waiver Level of Care (LOC) evaluations, LOC reevaluations, and providing ongoing administrative case management activities. Waiver participants must have a current POT signed by the participant and/or legal representative/legally responsible adult, the participant's primary care physician and all HCBS Waiver providers, that describes all the participant's care services, frequency and providers of the identified services that ensure his/her health and safety in a home and community setting.

Waiver services are delivered utilizing qualified and enrolled Medi-Cal HCBS Waiver providers, such as home health agencies, durable medical equipment companies, individual nurse providers, licensed clinical social workers, marriage and family therapists, personal care agencies, and individual personal care providers. The waiver participant has the option of selecting the provider of waiver services that are appropriate to his/her care needs.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. **Appendix A** specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

X	The waiver provides for participant direction of services. *Appendix E is required*.
O	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed*.

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Management Strategy. **Appendix H** contains the Quality Management Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these

payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. **Cost-Neutrality Demonstration.** **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

X	Yes
○	No
○	Not applicable

C. State wideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

○	**Yes** *(complete remainder of item)*
X	**No**

If yes, specify the waiver of statewideness that is requested :

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. S*pecify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants 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 waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative/legally responsible adult, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

3. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. **Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. **Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. **Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. **Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services**. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are:(1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3)

under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other

legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

The HCBS IHO waiver application has not received public input. However, this waiver application utilizes public input received in the preparation of the HCBS NF/AH Waiver during the public comment period and at the stakeholders briefing.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000

(65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Barbara
Last Name	Lemus
Title:	Chief, Waiver Analysis Section
Agency:	California Department of Health Services
Address 1:	MS 4615, P.O. Box 942732
Address 2:	1501 Capitol Avenue
City	Sacramento
State	CA
Zip Code	94234-7320
Telephone:	916-552-9633
E-mail	Blemus@dhs.ca.gov
Fax Number	916-552-9660

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	
Zip Code	

Telephone:	
E-mail	
Fax Number	

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____ **Date:** _____

State Medicaid Director or Designee

First Name:	Stan
Last Name	Rosenstein
Title:	Deputy Director, Medical Care Services
Agency:	California Department of Health Services
Address 1:	MS 4000, PO Box 942732
Address 2:	1501 Capitol Ave
City	Sacramento
State	CA
Zip Code	94234-7320
Telephone:	916-440-7800
E-mail	SRosenst@dhs.ca.gov
Fax Number	916-440-7805

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

The following plan is designed to provide an orderly and timely transition of participants in the Nursing Facility A and B (NF A/B) Level of Care, NF Subacute (SA) and In-Home Medical Care (IHMC) Waivers into either the new HCBS IHO Waiver or the reconfigured NF A/B Waiver now titled as the Nursing Facility/Acute Hospital (NF/AH) Waiver. The HCBS IHO Waiver will have qualified participants from the NF A/B and NF SA waivers. The NF/AH Waiver will have participants from the NF A/B, NF SA and IHMC waivers. After this migration takes place, there will be no participants left in the NF SA and IHMC waivers and these waivers will be terminated.

The proposed timing of this transition is framed by the following requirements:

1. Prospective HCBS IHO and NF/AH waiver participants who are currently enrolled in the existing waivers must be given 30 days advance notice of the termination or modification of their current waiver program and the opportunity to make an informed decision about their right to choose enrollment in either the HCBS IHO or NF/AH waiver, institutionalization, or enrollment in another Medicaid program suitable to their needs. This notice will provide adequate information about the changes taking place so that participants and/or their representatives will be able to make an informed choice of their Medi-Cal service options.

2. The State must provide CMS with a 90-day notice of its intention to terminate two HCBS waivers, the NF SA Waiver and the IHMC Waiver. This notice will provide a description of the changes that will occur in the California waiver system and how the State will assure that the Medicaid assurances will continue to be met for all affected waiver participants.

3. Within 6 months prior to the release of the notices, the State will conduct a comprehensive redetermination of every participant in the current NF A/B , NF SA and IHMC waivers and in targeted NF DP facilities to determine for each individual their level of care and sub-category (for NF LOC participants) and verify and revise as appropriate, each individual's plan of treatment (POT) or plan of care.

The transition plan will proceed as follows.

In chronological order:

7/1/06 – 12/31/06 – State redetermination of LOC and reassessment of POT for each individual targeted for enrollment in the HCBS IHO and NF/AH HCBS waivers.

11/15/06 – Issuance of State Transition Plan explaining how participants in the current NF A/B, NF SA and IHMC waivers will be disenrolled from their current waivers and reenrolled simultaneously in the revised NF/AH (formerly NF Level A/B) Waiver or in the HCBS IHO Waiver during the enrollment period 1/2/07 - 2/17/07. The NF SA and IHMC waivers will be terminated 2/28/07.

12/28/06 – CMS deadline for approval of the new HCBS IHO Waiver and the renewed NF A/B Waiver, now entitled the NF/AH Waiver.

12/1/06 – Issuance of a Transition Letter notifying all participants in the NF Level A/B, NF SA and IHMC waivers of their transition to either the HCBS IHO or NF/AH waivers effective 1/15/07. The letter will assure the participant that there will be no disruption in his/her services or providers during the transition.

1/1/07 – 2/15/07 – Transfer of HCBS waiver participants who do not accept enrollment in the HCBS IHO or NF/AH waivers into other Medi-Cal programs appropriate to their assessed LOC and individual needs.

2/28/07 – Last date of service for NF SA and IHMC waiver services which will be accepted for purposes of FFP. The last provisional 372 report for these waivers will be due for submission to CMS 6 months later (8/31/07) and the last final 372 report will be due 8/31/08.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver *(select one)*:

X	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one; do not complete Item A-2*):		
	X	The Medical Assistance Unit *(name of unit)*:	Medical Care Services, Medi-Cal Operations Division, Home and Community-Based Services Branch
	○	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit)	
○	The waiver is operated by		
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *Complete item A-2.*		

2. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (*select one)*:

○	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
X	**No.** Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

4. **Role of Local/Regional Non-State Entities**. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity:

☐	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
☐	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a **contract** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:
X	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently

the performance of contracted and/or local/regional non-state entities is assessed:

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed :

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	X	☐	☐	☐
Assist individuals in waiver enrollment	X	☐	☐	☐
Manage waiver enrollment against approved limits	X	☐	☐	☐
Monitor waiver expenditures against approved levels	X	☐	☐	☐
Conduct level of care evaluation activities	X	☐	☐	☐
Review participant service plans to ensure that waiver requirements are met	X	☐	☐	☐
Perform prior authorization of waiver services	X	☐	☐	☐
Conduct utilization management functions	X	☐	☐	☐
Recruit providers	X	☐	☐	☐
Execute the Medicaid provider agreement	X	☐	☐	☐
Determine waiver payment amounts or rates	X	☐	☐	☐

Conduct training and technical assistance concerning waiver requirements	X	☐	☐	☐

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

INCLUDED	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
X	**Aged or Disabled, or Both**			
X	Aged (age 65 and older)			**X**
X	Disabled (Physical) (under age 65)			
☐	Disabled (Other) (under age 65)			
	Specific Aged/Disabled Subgroup			
☐	Brain Injury			☐
☐	HIV/AIDS			☐
X	Medically Fragile			**X**
X	Technology Dependent			**X**
○	**Mental Retardation or Developmental Disability, or Both**			
☐	Autism			☐
☐	Developmental Disability			☐
☐	Mental Retardation			☐
○	**Mental Illness**			

☐	Mental Illness (age 18 and older)			☐
☐	Serious Emotional Disturbance (under age 18)			

b. Additional Criteria. The State further specifies its target group(s) as follows:

Participants served under this HCBS IHO Waiver will need to have an identified support network system available to them in the event the HCBS provider of direct care services is not able to provide the total number of hours approved and authorized by CDHS/IHO. The support network system may consist of care providers, community-based organizations, family members, primary **care** physicians, home health agencies, a member of the participant's medical team, licensed foster parent or any other individual that is part of the participant's circle of support. The participant's circle of support may consist of family members, legal representative/legally responsible adult, and any other individual named by the participant. Members of the support network providing direct care services in the absence of the authorized HCBS waiver provider will be identified on the Plan of Treatment (POT). **The POT must be signed by the participant's primary physician. For purposes of the HCBS IHO Waiver, the primary physician is the physician that oversees the participant's home program.**

This waiver will serve Medi-Cal beneficiaries who would, in the absence of this waiver, and as a matter of medical necessity, pursuant to California Welfare and Institutions (W&I) Code, Section 14059, otherwise require care in an inpatient nursing facility (NF) providing the following types of care:

1. NF DP services pursuant to W&I Code §1409.21(c)(1), and California Code of Regulations (CCR), Title 22, CCR, § 51124 and 51335.
2. NF Level B Pediatric services pursuant to Title 22, CCR, s§51124 and 51335 and the participant is under the age of 21.
3. NF Subacute services, pursuant to Title 22, CCR, 51124.5, or
4. NF Pediatric Subacute services, pursuant to Title 22, CCR, §51124.6.

For each reevaluation the participant must continue to meet the criteria as described in the above cited W&I Code and CCR, in addition to those additional criteria outlined in this waiver application.

NF LOC waiver participants must also:

- Meet the criteria for care in a nursing facility for at least 365

consecutive days; or

- Be receiving continuous services in an acute hospital for 36-months or more, and have **primary care** physician ordered direct care services that are in excess of the NF/AH Waiver for the participant's LOC. All **primary care** physician-ordered services must be in place at the time of discharge from the acute hospital to ensure the participant's health and safety.
- All requests for NF waiver services shall meet the criteria set forth in Title 22, CCR, Section 51344(a) and (c).

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

X	Not applicable – There is no maximum age limit
○	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit:

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

○	**No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c*.
X	**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*. The limit specified by the State is *(select one)*:
	○ ____ %, a level higher than 100% of the institutional average
	X Other :
	Individuals eligible for transition to this waiver have established home program of care described in their individual Plan of Treatment (POT). Enrollment in this waiver is contingent on the waiver participant's acceptance of the enrollment requirement that establishes their current level of expenditure for the waiver and State plan services as described on their most recent POT as their individual cost limit.
○	**Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c*.
○	**Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c*.

The cost limit specified by the State is *(select one)*:

- ○ The following dollar amount: $ [redacted]

  The dollar amount *(select one)*:

  - ○ Is adjusted each year that the waiver is in effect by applying the following formula:
  - ○ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
- ○ The following percentage that is less than 100% of the institutional average: _____ %
- ○ Other – *Specify:*

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The CDHS/IHO NE utilizes the following procedures for waiver participants to determine, prior to transition or enrollment to the HCBS IHO Waiver:

1. The CDHS/IHO NE schedules a face-to-face intake visit with the waiver participant and completes an evaluation to determine if the participant meets one of the HCBS IHO Waiver's facility alternatives level of care (LOC). The CDHS/IHO NE documents the type, frequency and amount of waiver and State Plan services the participant is currently receiving or the **primary care** physician has ordered to ensure the health and safety of the participant at the time of discharge. The information from the visit is documented on the Case Report along with medical justification to support the LOC, facility type, and the need to receive the type, frequency and amount of services that are currently authorized or being requested to ensure the health and safety of the participant to return and/or remain safely in his/her home and community.

2. Upon determination of the participant's LOC and the need for the services, the CDHS/IHO NE provides information to the participant and/or his/her legal representative/legally responsible adult(s), and/or circle of support on the requirement that the participant's institutional cost limit is based upon the cost of his/her authorized waiver and State plan services that are described on the participant's current POT, for participants transitioning from the NF A/B or NF SA Waiver to the HCBS IHO Waiver or on the new POT, for participant's who meet the 36-month continuous care in an acute hospital criteria and meet the participant's current needs to remain safely in the home at the time of the assessment visit. For participants transitioning from the NF A/B or NF SA Waiver, the CDHS/IHO NE works with the participant and/or his/her legal representative/legally responsible adults and/or circle of support, the participant's **primary care** physician, and the HCBS IHO Waiver case manager in ensuring the services and provider types described on the participant's current POT will remain unchanged upon enrollment in the HCBS IHO Waiver. For participants who meet the 36-month continuous care criteria, CDHS/IHO NE works with the participant and/or his/her legal representative/legally responsible adults and/or circle of support, the participant's **primary care** physician, and the HCBS IHO Waiver case manager in obtaining services and provider types as ordered by the participant's **primary care** physician and are described on the participant's current POT. To ensure the participant's health and safety, participant's transitioning from the acute hospital to the HCBS IHO Waiver must have all their **primary care** physician-ordered services and providers in place prior to enrolling in the HCBS IHO Waiver.

   The type, frequency and amount of the participant's authorized waiver and State plan and Waiver services are documented in the Menu of Health Services (MOHS) worksheet and provided to the participant and/or his/her legal representative/legally responsible adult prior to enrolling in the HCBS IHO Waiver. The MOHS is a planning instrument used by the participant and/or his/her legal representative/legally responsible adult, circle of support, HCBS IHO Waiver Case Manager, and the CDHS/IHO NE to ensure the costs of the participant's selected services do not exceed the participant's cost limit. The MOHS summarizes all the waiver services and provider types available through the HCBS IHO Waiver. The MOHS enables the participant and/or his/her legal representative/legally responsible adult(s) and/or his/her circle of support to select a combination of

waiver services best suited to meet his/her medical care needs and ensure his/her health and safety and ensure the costs of the services do not exceed the participant's cost limit.

3. If the participant and/or his/her legal representative/legally responsible adult does not agree to accept their established cost limit as a condition enrollment, CDHS IHO will issue a Notice of Action denying enrollment in the HCBS IHO Waiver due to not meeting the waiver's cost neutrality requirements.

The HCBS IHO Waiver cost neutrality is calculated in the aggregate as described in Appendix B-2 and detailed in Appendix J-1 for the NF DP and NF SA Medi-Cal reimbursement rate. Increases in the Medi-Cal aggregate costs limit require the approval by the California Department of Finance, authorization of the State Legislature of appropriations to support an increase in expenditures and CMS' approval to amend the HCBS IHO Waiver to increase the waiver aggregate cost limits.

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant :

☐	The participant is referred to another waiver that can accommodate the individual's needs.
☐	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
X	Other safeguard(s) :

When there is a change in the participant's condition or circumstances post entrance to the waiver that requires the provision of services in an amount exceeding the cost limit, the following safeguards have been established to avoid an adverse impact on the participant and to ensure compliance with the terms of the waiver:

1. If there is change in the type, frequency and amount of the selected waiver or State plan services that exceed the participant's institutional cost limit, the CDHS/IHO NE will work with the participant and/or his/her legal representative/legally responsible adult and/or circle of support and HCBS IHO Waiver Case Manager in identifying services that will meet the participant's health and safety needs and not exceed the participant's cost limit.
2. The participant is reevaluated to determine if he/she meets the criteria for another LOC and/or facility type covered in this waiver. Upon determination of a change in the LOC and facility type, the appropriate institutional cost limit will be used in the MOHS to determine if the cost of the participant's services to ensure his/her health and safety meet the waiver's cost neutrality requirement.
3. If the cost of the participant's services exceed his/her cost limit and the participant does not meet the criteria for another LOC and facility type within this waiver, the CDHS/IHO NE will contact the participant and/or his/her legal representative/legally responsible adult, the participant's HCBS IHO Waiver Case Manager, and the participant's **primary care** physician to discuss alternative options, which may include transfer to another California HCBS Waiver, providing additional State plan services (if available and/or appropriate) or admission into a facility.

Appendix B-3: Number of Individuals Served

a. **Unduplicated Number of Participants**. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

	Table: B-3-a Unduplicated Number of Participants		
Waiver Year	**Nursing Facility B LOC**	**Nursing Facility Subacute LOC**	**Total**
Year 1	158	52	210
Year 2	158	52	210
Year 3	158	52	210
Year 4	-	-	-
Year 5	-	-	-

b. **Limitation on the Number of Participants Served at Any Point in Time**. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

○	The State does not limit the number of participants that it serves at any point in time during a waiver year.
X	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	210
Year 2	210
Year 3	210
Year 4 (renewal only)	-
Year 5 (renewal only)	-

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

X	**Not applicable.** The state does not reserve capacity.
○	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c		
Waiver Year	**Purpose:**	**Purpose:**
	Capacity Reserved	**Capacity Reserved**
Year 1		
Year 2		
Year 3		
Year 4		
Year 5		

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

X	The waiver is not subject to a phase-in or a phase-out schedule.
○	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

e. **Allocation of Waiver Capacity.** *Select one:*

X	Waiver capacity is allocated/managed on a statewide basis.

○	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Each year beginning January 1, 2007, the maximum unduplicated count of participants enrolled in the HCBS IHO Waiver will not exceeded the capacity described in Appendix B-3(a). Enrollment is based upon a first come first serve process. An individual requesting HCBS IHO Waiver services must complete and submit a HCBS Waiver Application to IHO. The CDHS/IHO NE will identify the applicant's need for the HCBS IHO Waiver based on the information provided. If waiver slots are available, the CDHS/IHO NE will schedule a face-to-face meeting to assess the individual for enrollment and provide the participant and/or legal representative/legally responsible adult with information on the HCBS IHO Waiver. If there are no waiver slots available, potential waiver participants who meet the waiver's LOC criteria, will be placed on the waiting list. CDHS/IHO will send a letter confirming receipt of the completed HCBS Waiver Application, indicating the effective date of placement on the HCBS IHO Waiver waiting list.

Unused waiver capacity is referred to as available "waiver slots" for purposes of establishing and maintaining a waiting list for enrollment. Enrollment into the HCBS IHO Waiver is limited to the maximum number of waiver slots authorized for each waiver year. When there are no available waiver slots during the waiver year, the Department, through CDHS/IHO, will establish and maintain a waiting list of individuals eligible for potential enrollment in the CDHS IHO Waiver. Waiver slots that become available due to the death of a participant will be filled with a new participant from the appropriate waiting list.

Multiple completed HCBS Waiver Applications received on the same day shall be prioritized numerically based upon the applicant's birth date, 1 through 31, without consideration to the month or year.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. Waiver Years Subject to Phase-In/Phase-Out Schedule:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

c. Phase-In/Phase-Out Time Period. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
		Waiver Year:	
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

X	§1634 State
○	SSI Criteria State
○	209(b) State

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
X	Low income families with children as provided in §1931 of the Act		
X	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
X	Optional State supplement recipients		
X	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	X	100% of the Federal poverty level (FPL)	
	○	%	of FPL, which is lower than 100% of FPL
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
☐	Disabled individuals age 18 or younger who would require an		

	institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
X	Medically needy
X	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:
	All other mandatory and optional eligibility groups under the Medi-Cal State Plan are included.

Special home and community-based waiver group under 42 CFR §435.217)
Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

○	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
X	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5*.

	X	All individuals in the special home and community-based waiver group under 42 CFR §435.217		
	○	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 :		
		☐	A special income level equal to (select one):	
			○	300% of the SSI Federal Benefit Rate (FBR)
			○	% of FBR, which is lower than 300% (42 CFR §435.236)
			○	$ which is lower than 300%

	☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)	
	☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)	
	☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)	
	☐	Aged and disabled individuals who have income at: *(select one)*	
		○	100% of FPL
		○	% of FPL, which is lower than 100%
	☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:	

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

X	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):	
	X	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.*
	○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
○	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1 Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i.	**Allowance for the needs of the waiver participant** (*select one*):
○	The following standard included under the State plan *(select one)*

	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one):*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%?
	○	%	of the Federal poverty level	
	○	Other :		

○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		

ii. **<u>Allowance for the spouse only</u>** (*select one*):

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
	Not applicable *(see instructions)*		

iii. **<u>Allowance for the family</u>** *(select one)*:

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the

	higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other :
	Not applicable (see instructions)
iv. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**	
i. Health insurance premiums, deductibles and co-insurance charges	
ii. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*	
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits :

c-1 Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

a. **<u>Allowance for the needs of the waiver participant</u>** (*select one*):		
○	The following standard included under the State plan *(select one)*	
[redacted]	○	The following standard under 42 CFR §435.121:
	○	Optional State supplement standard
	○	Medically needy income standard

	○	The special income level for institutionalized persons *(select one)*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○	%		of the Federal poverty level
	○	Other :		

○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		

b. **<u>Allowance for the spouse only</u>** (*select one*):

○	The following standard under 42 CFR §435.121
○	Optional State supplement standard
○	Medically needy income standard

○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		

○	Not applicable *(see instructions)*

c. **<u>Allowance for the family</u>** *(select one)*

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher
	of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.		

○	The amount is determined using the following formula:
○	Other :
○	Not applicable (see instructions)

d. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:**

i. Health insurance premiums, deductibles and co-insurance charges

ii. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits :

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2 Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

1. **<u>Allowance for the needs of the waiver participant</u>** (*select one*):

X	The following standard included under the State plan *(select one)*	
	○	SSI standard
	○	Optional State supplement standard
	○	Medically needy income standard
	○	The special income level for institutionalized persons *(select one):*

	○	300% of the SSI Federal Benefit Rate (FBR)	
	○	%	of the FBR, which is less than 300%
	○	$	which is less than 300%?
○		%	of the Federal poverty level
	Other :		

○	The following dollar amount:	$	If this amount changes, this item will be revised.
X	The following formula is used to determine the needs allowance:		
	An amount which represents the sum of (1) the income standard used to determine eligibility and (2) any amounts of income disregarded during the Section 1902(a)(10)(A)(ii)(VI) eligibility phase.		

2. <u>Allowance for the spouse only</u> (*select one*):

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
	Specify the amount of the allowance:		
	○	SSI standard	
	○	Optional State supplement standard	
	○	Medically needy income standard	
	○	The following dollar amount:	$	If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:	
X	Not applicable		

3. <u>Allowance for the family</u> *(select one)*:

○	AFDC need standard
○	Medically needy income standard

○	The following dollar amount:	$	The amount specified cannot exceed the higher of the
	need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.		
○	The amount is determined using the following formula:		
○	Other :		
X	Not applicable (see instructions)		
	4. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:		
1. Health insurance premiums, deductibles and co-insurance charges			
2. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*			
X	The State does not establish reasonable limits.		
○	The State establishes the following reasonable limits :		

c-2 Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

	a. <u>Allowance for the needs of the waiver participant</u> (*select one*):	
○	The following standard included under the State plan *(select one)*	
	○	The following standard under 42 CFR §435.121:

	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one)*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level	
	○	Other :		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:			

b. <u>Allowance for the spouse only</u> (*select one*):

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:			
	Specify the amount of the allowance:			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The following dollar amount:	$	If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:		
○	Not applicable			

c. <u>Allowance for the family</u> *(select one)*

○	AFDC need standard

○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher
	of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.		
○	The amount is determined using the following formula:		
○	Other :		
○	Not applicable (see instructions)		
	d. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:		
	a. Health insurance premiums, deductibles and co-insurance charges		
	b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*		
○	The State does not establish reasonable limits.		
○	The State establishes the following reasonable limits :		

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

• **Allowance for the personal needs of the waiver participant** *(select one)*:			
○	SSI Standard		
○	Optional State Supplement standard		
○	Medically Needy Income Standard		
○	The special income level for institutionalized persons		
○	%	of the Federal Poverty Level	
○	The following dollar amount:	$	If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:		
X	Other **:**		
	An amount which represents the sum of (1) the income standard used to determine eligibility and (2) any amounts of income disregarded during the Section 1902(a)(10)(A)(ii)(VI) eligibility phase.		
• **If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.** ***Select one:***			
X	Allowance is the same		
○	Allowance is different. Explanation of difference:		
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:			

• Health insurance premiums, deductibles and co-insurance charges. • Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*	
X	The State does not establish reasonable limits.
○	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is *(insert number):*	
	One	
ii.	**Frequency of services**. The State requires *(select one)*:	
	X	The provision of waiver services at least monthly
	○	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

X	Directly by the Medicaid agency
○	By the operating agency specified in Appendix A
○	By an entity under contract with the Medicaid agency. *Specify the entity*:
○	Other :

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Registered Nurse (RN), licensed in the State and who is an employee of CDHS/IHO. A physician (M.D. or D.O.) licensed in the State and who is an employee of CDHS/IHO.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The criteria used for waiver LOC is determined by criteria established in Title 22, CCR Division 3, Sections 51124, 51124.5, 51124.6, and 51335 as well as information submitted to support medical necessity for the services as defined in Title 22, CCR Section 51003. Together this information is used during the initial and ongoing reevaluations of all waiver services provided through the HCBS IHO Waiver.

This waiver will serve disabled Medi-Cal beneficiaries, who would, in the absence of this waiver, and as a matter of medical necessity, pursuant to W&I Code section 14059, otherwise require care in a health care facility providing the following types of care:

- NF DP services pursuant to W&I Code §14091.21(c)(1) and CCR, Title 22, §51124 and 51335,
- NF Level B Pediatric services pursuant to Title 22, CCR, §51124 and 51335 and are under the age of 21.
- NF Subacute services, pursuant to Title 22, CCR §51124.5 or
- NF Pediatric Subacute services, pursuant to Title 22, CCR, §51125.6

The Case Report as described in Appendix B-6:3 is used after the initial evaluation and later reevaluations to document if the participant continues to meet waiver requirements. The Case Report is reviewed by the CDHS/IHO NE Supervisor, a R.N. licensed to practice in the State of California, to determine if the CDHS/IHO NE's LOC determination is correct and that the home safety evaluation was performed and completed. The LOC determinations are reviewed by the CDHS/IHO Medical Consultant, a physician licensed to practice in the State of California. On approval of the LOC determination, both the CDHS/IHO NE and CDHS/IHO NE Supervisor sign the Case Report.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

X	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
○	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The CDHS/IHO NE conducts a complete LOC evaluation/reevaluation of the participants for waiver services. The evaluation and reevaluations for LOC are documented in the Case Report. The evaluation and reevaluations include identification of **a primary care** physician who provides the participant's specific written orders; a complete and accurate written medical record including diagnoses, history, physical assessment, treatment plan, and prognosis', confirmation that a medical need exists for the level of services requested, and a determination that the services to be provided do not exceed the participant's institutional cost limit.

For a complete description of the LOC criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver, refer to Appendix B Section 1.b. Once the evaluation visit is completed, the CDHS/IHO NE uses the Case Report to document the individual's LOC and medical care needs, including identification of caregivers, and support systems; a home safety evaluation; and concerns or issues identified by the individual, his/her circle of support, or caregivers needing resolution before the individual can be enrolled into the waiver. The Case Report also documents plans for resolution of issues identified during the evaluation for waiver enrollment. The CDHS/IHO NE provides a justification and recommendation for the individual's LOC in the Case Report.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

○	Every three months
○	Every six months
○	Every twelve months
X	Other schedule :

The CDHS/IHO NE uses the Case Management Acuity System to determine the periodicity of LOC reevaluations and the intensity of the required participant case management. Information collected during the initial evaluation and later reevaluations for LOC is documented in the Case Report and is used to determine a participant's level of case management. HCBS IHO Waiver participants are assigned a level of case management of 1-4, which is based on factors such as a participant's medical stability, compliance with the POT, issues affecting participant health and safety, and availability and adequacy of staffing for waiver services. The CDHS/IHO NE will conduct on-site home visits based upon the level of case management acuity, or as necessary, to assess the effectiveness of the home program in ensuring the participant's health and safety and adherence to the POT.

a. Participants assigned ***Level 1*** are reevaluated at least once every 365 days. Level 1 participants are medically stable, have not recently been hospitalized for emergency care, and have no eligibility or staffing issues.
b. ***Level 2*** participants are reevaluated more often, at least every 365 days, and up to 180 days. Participants have minor staffing or durable medical equipment issues, which are addressed timely by the HCBS provider responsible for rendering waiver case manager services. The waiver case manager maintains regular contact with the CDHS/IHO NE, providing updates to the POT and/or documentation of the issues, corrective actions taken, and outcomes.
c. ***Level 3*** participants are reevaluated at least every 180 days. Participants assessed at Level 3 can be dependent on medical technology, elected to have non-licensed providers render all of their direct-care services, have high turnover of waiver providers, have had four or more unscheduled hospitalizations in the previous 12 month period, and/or had difficulty in obtaining **primary care** physician ordered medically-necessary services. The CDHS/IHO NE will assist the participant and/or his/her legal representative/legally responsible adults and/or circle of support and waiver case manager in identifying areas of concern and taking corrective actions, and will monitor the outcome.
d. ***Level 4*** participants are reevaluated at least once every 180 days or more frequently. Level 4 participants are at an elevated risk and require frequent monitoring and interventions by the CDHS/IHO NE to address issues that affect their health and safety. Participants evaluated at level 4 may have related issues suspected or reported domestic violence, abuse, neglect, or exploitation, or a lack of providers to meet their medical care needs and ensure their health and safety. The CDHS/IHO NE conducts frequent on-site visits to

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

X	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
○	The qualifications are different. The qualifications of individuals who perform reevaluations are :

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care:

Monthly reports are generated from a CDHS/IHO database. The database tracks the date of last evaluation and the date when the participant requires a reevaluation. Monthly tracking reports are distributed to the CDHS/IHO NEs and the CDHS/IHO NE Supervisors for workload planning and scheduling of home visits to ensure the timeliness of the reevaluation visits.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The LOC evaluation records and reevaluations are maintained in a participant's case record file with the assigned CDHS/IHO NE.

Appendix B-7: Freedom of Choice

***Freedom of Choice**. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative/legally responsible adult is:*

a. informed of any feasible alternatives under the waiver; and
b. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representative/legally responsible adults) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver participants and/or their legal representative/legally responsible adult(s) are informed of the right to accept or decline waiver enrollment and waiver services during the initial evaluation and later revaluations for continued enrollment in the HCBS IHO Waiver. Information is provided verbally and in writing through use of the "Freedom of Choice" form and "Informing Notice" letter.

A signed "Freedom of Choice" form is required of all participants at the onset of waiver enrollment and before authorization of waiver services or when declining waiver services. After initial evaluation for Waiver enrollment, the CDHS/IHO NE sends to the participant and/or his/her legal representative/legally responsible adult(s) a "Freedom of Choice" letter and form for their signature. The participant's and/or his/her legal representative/legally responsible adult(s)' signature is acknowledgment that the CDHS/IHO NE has described the services available under the HCBS IHO Waiver which are provided as an alternative to care in a licensed heath care facility. The "Freedom of Choice" letter advises the participant and/or his/her legal representative/legally responsible adult(s) of the right to utilize qualified waiver service providers of their choice.

Enclosed with the "Freedom of Choice" form and letter is the "Informing Notice" which describes the roles and responsibilities of the participant, his/her legal representative/legally responsible adults, the waiver providers, and the **primary care** physician. The "Informing Notice" is resent whenever there is a change in the provider of service or

the participant's **primary care** physician.

The participant and/or his/her legal representative/legally responsible adult(s) are advised to return the signed and dated "Freedom of Choice" form within five days of receipt.

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The signed HCBS "Freedom of Choice" form is maintained in the participant's case record file at the designated CDHS IHO office.

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The following is representative of the Department:

Medi-Cal statewide threshold languages are Armenian, Cambodian, Cantonese, Farsi, Hmong, Korean, Mandarin, other Chinese, Russian, Spanish, Tagalog, and Vietnamese. A "threshold" is defined as "3,000 beneficiaries or 5% of the Medi-Cal population, whichever is lower, whose primary language is other than English."

In addition to translated materials, CDHS offers Limited English Proficient (LEP) individuals the opportunity to request an interpreter to translate, furnish translation aids, or translate written materials and will ensure that there is no significant delay in services. These services are provided at no cost.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. **Waiver Services Summary**. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services		
Service	Included	Alternate Service Title (if any)
Case Management	**X**	
Homemaker	☐	
Home Health Aide	☐	
Personal Care	**X**	Waiver Personal Care Services
Adult Day Health	☐	
Habilitation	**X**	Habilitation Services
Residential Habilitation	☐	
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☐	
Supported Employment	☐	
Education	☐	
Respite	☐	
Home Respite	**X**	
Facility Respite	**X**	
Day Treatment	☐	
Partial Hospitalization	☐	

Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
X	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a	Community Transition Services
b.	Environmental Accessibility Adaptations
c.	Family Training
d.	Personal Emergency Response Systems
e.	Personal Emergency Response Systems - Installation and Testing
f.	Private Duty Nursing, including shared services
g.	Transitional Case Management
h.	Medical Equipment Operating Expenses

Extended State Plan Services *(select one)*	
X	Not applicable
○	The following extended State plan services are provided:
a.	
b.	

Supports for Participant Direction *(select one)*	
○	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
X	Not applicable

Support	Included	Alternate Service Title (if any)

Information and Assistance in Support of Participant Direction	☐	
Financial Management Services	☐	
Other Supports for Participant Direction *(list each support by service title)*:		
a.		
b.		

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants:

☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c*.
X	As an administrative activity. *Complete item C-1-c.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

A California Department of Health Services (CDHS)/In-Home Operations (IHO) Nurse Evaluator (NE), licensed as a Registered Nurse (R.N.) in the State of California and employed by HCBS IHO, provides administrative case management services. The CDHS/IHO NE is assisted by the CDHS/IHO NE Supervisor, a licensed R.N. in the State of California and employed by HCBS IHO and a CDHS/IHO Medical Consultant, a licensed physician (M.D. or D.O.) employed by the Home and Community-Based Services (HCBS) Branch who provides medical consultant services to HCBS IHO.

Appendix C-2: General Service Specifications

a. **Criminal History and/or Background Investigations**. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services-*(select one)*:

○	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
X	**No**. Criminal history and/or background investigations are not required.

b. **Abuse Registry Screening**. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry *(select one)*:

○	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
X	**No**. The State does not conduct abuse registry screening.

c. **Services in Facilities Subject to §1616(e) of the Social Security Act**. *Select one*:

X	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
○	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of

	facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following:

Standard	Facility Type	Facility Type	Facility Type	Facility Type
Admission policies	☐	☐	☐	☐
Physical environment	☐	☐	☐	☐
Sanitation	☐	☐	☐	☐
Safety	☐	☐	☐	☐
Staff: resident ratios	☐	☐	☐	☐
Staff training and qualifications	☐	☐	☐	☐
Staff supervision	☐	☐	☐	☐
Resident rights	☐	☐	☐	☐
Medication administration	☐	☐	☐	☐
Use of restrictive interventions	☐	☐	☐	☐

Incident reporting	☐	☐	☐	☐
Provision of or arrangement for necessary health services	☐	☐	☐	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

X	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○	The State does not make payment to relatives/legal guardians for furnishing waiver services.
X	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
	Under certain very limited circumstances, a parent, stepparent, foster parent of a minor, a spouse or legal guardian of a waiver participant, hereto referred to as legal representative/legally responsible adult, may provide select HCBS IHO Waiver services. CDHS/IHO will authorize the participant's legal representative/legally responsible adult to provide HCBS IHO Waiver services upon evidence the legal representative/legally responsible adult: 1) has an active Medi-Cal provider number with a HCBS waiver category of service indicator; 2) meets waiver licensing and/or certification requirements; 3) meets the HCBS provider standards described in Appendix C-4; 4) meets the HCBS IHO Waiver SOP; and 5) provides evidence of the inability to hire a local licensed professional who meets the service requirements in the participant's plan of treatment. The evidence of inability to hire a local licensed professional must document that: 1) there are no available providers; 2) the participant lives in a remote or rural area experiencing shortages of licensed professionals; 3) the participant's waiver cost neutrality can be achieved or maintained only by using the legal representative/legally responsible adult as the provider of the HCBS waiver service; 4) attempts were made to enlist and retain a qualified provider, such as the posting of classified advertisements, or contacting home health agencies or professional corporations; and 5) there is an accounting of interviews with potential providers including the reasons the provider was not selected or refused to

	provide the waiver service(s). Legal representative/legally responsible adults who meet the Medi-Cal and HCBS IHO Waiver provider standards may provide the following HCBS IHO Waiver services: ▪ Case Management; ▪ Community Transition Services ▪ Environmental Accessibility Adaptations; ▪ Family Training; ▪ Private Duty Nursing; ▪ Habilitation Services; ▪ Respite Home; and ▪ Transitional Case Management ▪ Medical Equipment Operating Expense. CDHS/IHO will notify the waiver participant and/or his/her legal representative/legally responsible adult of the decision to approve or deny the legal representative/legally responsible adult's request to provide waiver services by either authorizing the requested service(s) or issuing a Notice of Action (NOA).
○	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
○	Other policy. *Specify*:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Continuous and open enrollment is afforded to any willing and qualified provider who meets Medi-Cal and HCBS IHO Waiver provider qualifications. Licensed providers must demonstrate they meet applicable state licensure

requirements. Non-licensed providers must demonstrate they have the necessary skills to provide services as described on the POT. Information on how interested providers can become an HCBS IHO Waiver provider is available online at the Medi-Cal website under the Provider Enrollment Branch (PEB). Enrollment information is available in the Medi-Cal Provider Manual, which is distributed at statewide CDHS/IHO presentations, and available on request. The HCBS IHO Waiver Standards of Participation (SOP) are included as an attachment to this waiver application.

CDHS/IHO has expedited the provider enrollment process to ensure waiver participants have timely access to the HCBS IHO Waiver providers of his/her choice. PEB and HCBS IHO have developed a provider information packet for licensed providers that includes:

- HCBS IHO Waiver Standards of Participation;
- Medi-Cal Provider Application forms and instructions;
- Forms and instructions for requesting authorization to provide HCBS IHO Waiver services;
- Forms and instructions for submitting claims for payment of approved HCBS IHO Waiver services that have been rendered; and
- Information on who to contact for questions or problems.

The provider is instructed to return the completed provider application to CDHS/IHO. CDHS/IHO reviews the application to determine if the provider meets the waiver's SOP. Upon approval, CDHS/IHO transmits the application to PEB who will determine if the provider meets the Medi-Cal provider requirements. Upon PEB approval, the provider is issued a Medi-Cal provider number with the category of service code that allows them to render and be reimbursed for HCBS IHO Waiver services. The expedited provider enrollment process is completed within 21 working days of PEB's receipt of a complete and accurate application and all required attachments.

Annually, the CDHS/IHO NE verifies that the provider of waiver services continues to meet the waiver program requirements through onsite provider visits and a review of the provider status in the Medi-Cal Eligibility Data System (MEDS) for licensed providers, and Case Management Information Payrolling System (CMIPS) for non-licensed providers.

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	**Case Management**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Case management services are designed to assess the participant and determine their need for medical, social and other services, and to assist them in gaining access to those needed services, regardless of the funding source, to ensure the participant's health and safety and support of his/her home and community-based program. Case managers also assist in acquiring personal care providers as described in the participant's plan of care. Case managers work with the participant, his/her legal representative/legally responsible adult and/or circle of support, and **primary care** physician in developing goals and identifying a course of action to respond to the assessed needs of the participant, and in the development and updating of the participant's **primary care** physician-signed POT. Case managers assist the participant in understanding the various services he/she is receiving or may receive and the impact, if any, of the services received/requested, based on the source of funding, as well as oversee the implementation of the services described in the POT, and evaluate the effectiveness of those services. Case management responsibilities include assessing, care planning, locating, coordinating, and monitoring services for community-based participants on the waiver. Case management services do not include the direct delivery of any service. HCBS RN providers providing case management services also supervise, monitor, and train HCBS LVN providers of private duty nursing services. Waiver participants may select case management services for monitoring and training his/her Waiver Personal Care Service (WPCS) providers. A WPCS provider is an individual employed directly by the waiver participant receiving WPCS services.	

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
None

Provider Specifications				
Provider Category(s):	X	Individual. List types:	X	Agency. List the types of agencies:
	HCBS Registered Nurse		Home Health Agency	
	HCBS Benefit Provider		Professional Corporation	
			Non-Profit Agency	

Specify whether the service may be provided by:	X	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License	Certificate	Other Standard
HCBS Registered Nurse	BPC §§2725 et seq. Title 22, §51067; Title 16, §§1409-1419.4		HCBS IHO Waiver Standards of Participation
HCBS Benefit Provider -Marriage Family Therapist	BPC §§4980-4989 Title 16, §§1829-1848		HCBS IHO Waiver Standards of Participation
HCBS Benefit Provider -Licensed Psychologist	BPC §§2909 et seq. Title 16, §§1380 et seq.		HCBS IHO Waiver Standards of Participation
HCBS Benefit Provider -Licensed Clinical Social Worker	BPC §§4990-4998.7 Title 16, §§1870-1881		HCBS IHO Waiver Standards of Participation
Home Health Agency – Registered Nurse	**HHA** Title 22, §§74659 et seq. **RN** BPC §§2725 et seq. Title 22, §51067; Title 16, §§1409-1419.4		
Professional Corporation	CC §13401(b)		HCBS IHO Waiver Standards of Participation

Non-Profit Agency	Business license, appropriate for the services purchased		HCBS IHO Waiver Standards of Participation

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered Nurse	California Board of Registered Nursing	Biennially
Marriage Family Therapist	California Board of Behavioral Sciences	Annually
Licensed Psychologist	California Board of Psychology	Biennially
Licensed Clinical Social Worker	California Board of Behavioral Sciences	Annually
Home Health Agency	CDHS Licensing and Certification	Annually
Professional Corporation	CDHS Licensing and Certification	Annually
Non-Profit Agency	California Attorney General's Registry of Charitable Trusts	Annually

Service Delivery Method

Service Delivery Method:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Waiver Personal Care Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

The WPCS benefit is designed to assist the waiver participant in gaining independence in his/her activities of daily living and preventing social isolation. These services assist the waiver participant in remaining in his/her residence and continuing to be part of the community. WPCS must be described in the participant's **primary care** physician-signed POT, which must be signed by the participant or his/her legal representative/legally responsible adult(s) or circle of support, the participant's **primary care** physician, and each WPCS provider. A waiver participant must be enrolled in and receiving personal care services through the federally funded State Plan Personal Care program in order to be eligible for WPCS benefits provided by a WPCS provider. If the personal care services are provided through a Personal Care or Employment Agency, then enrollment in the federally funded State Plan Personal Care program is not a requirement for the waiver participant.

The WPCS benefit includes:

- Assistance to Independence in Activities of Daily Living (ADL): Assisting the participant in reaching a self-care goal, the WPCS provider promotes the participant's ability in obtaining and reinforcing his/her highest level of independence in ADLs. The WPCS provider provides assistance and feedback to the participant in an effort to help him/her reach specific self-care goals in performing or directing his/her caregivers in an activity without assistance from others. Services provided by the WPCS provider are verbal cueing, monitoring for safety and completeness, reinforcement of the participant's attempt to complete self-directed activities, advising the primary caregiver of any problems that have occurred; providing information for updating the participant's POT and addressing any self-care activities with an anticipated goal completion date.
- Adult Companionship: Adult companionship is for waiver participants who are isolated and/or may be homebound due to his/her medical condition. Adult companions must be at least 18 years of age and able to provide assistance to

participants enrolled in the waiver. Waiver participants utilizing Adult Companionship must be at least 18 years old. Adult Companion services include non-medical care, supervision, and socialization provided to a waiver participant who is enrolled and receiving State Plan personal care services authorized under Welfare and Institutions (W&I) Code section 14132.95. To help maintain waiver participant's psychological well-being, adult companions may assist waiver participants in accessing self-interest activities or accessing activities in the local community for socialization and recreational purposes, and/or providing or supporting an environment conducive to interpersonal interactions. Adult companionship must be documented on the POT and identify a therapeutic goal along with the process to obtain the goal. Documentation of the need for adult companionship, the goal, process for obtaining the goal and progress in meeting the goal must be identified on the POT and submitted to the CDHS/IHO NE, for the initial and reauthorization of services.

- The WPCS Benefit While Participant is Admitted in a Health Care Facility: WPCS providers may be paid while the participant is admitted in a health care facility (as defined in Health and Safety Code section 1250) for services provided outside the health care facility setting for a maximum of seven days for each admission to a health care facility (or for the length of the admission to the health care facility, whichever period is shorter). This payment is necessary to retain the WPCS provider for the continuation of services and facilitate the waiver participant's transition back to his/her home environment. In order to receive WPCS benefits while admitted in a health care facility, the waiver participant must be enrolled and currently receiving State Plan personal care services as authorized by W&I Code section 14132.95 and receiving WPCS benefits within the prior month of the admission into the health care facility. Each time the participant is admitted in a health care facility, the WPCS provider must submit written documentation to CDHS/IHO describing the specific activities performed, the amount of time each activity required, and the total hours they worked (e.g., 7:00 a.m. to 11:00 a.m. and 2:00 p.m. to 4:00 p.m.).

  When the participant is admitted to a health care facility, the WPCS provider can provide:

  1. Routine housekeeping in the participant's absence;
  2. Collection of mail and other deliverables in the participant's absence and contacting/visiting the participant to assist in responding to mail;
  3. Food shopping for the participant's return to home;
  4. Assistance in obtaining medications and medical supplies for the participant's return to home; and

5. Availability to accept delivery of durable medical equipment and supplies to the participant's home.

WPCS providers will not be paid for care that duplicates the care required to be provided by the health care facility to the waiver participant while in the health care facility, that may include, but is not limited to, bathing, feeding, ambulation, or direct observation of the waiver participant.

Provider Requirements

WPCS providers under this waiver are the following:

1. An individual enrolled in the Medi-Cal Program as a WPCS provider who is not otherwise employed by an employment agency, personal care agency, or home health agency and is an individual who is employed directly by the Medi-Cal participant receiving WPCS services under the waiver. Medi-Cal providers are permitted to enroll in the Medi-Cal program as a Personal Care Service provider pursuant to W&I Code section 14132(t) and Title 22, California Code of Regulations (CCR), section 51246. WPCS providers must meet the same criteria for participation in the Medi-Cal program as required for providers of Personal Care Services. If the WPCS provider is also the Personal Care Services provider to the same Medi-Cal participant, and is reimbursed under the State Plan, then that provider must also enroll in the Medi-Cal program as an WPCS provider.
2. An Employment Agency, as defined in the HCBS IHO Waiver SOP;
3. A Personal Care Agency, as defined in the HCBS IHO Waiver SOP;
4. A Home Health Agency (HHA) WPCS provider. Pursuant to the authority under W&I Code section 14132(t) and Title 22, CCR, section 51246, a HHA WPCS provider enrolled in the waiver shall meet the same definition of and criteria for participation as required for participation in the Medi-Cal program. A HHA WPCS provider shall only be reimbursed for WPCS services provided pursuant to the waiver.
5. **In-Home Supportive Services (IHSS) Public Authorities, as defined in the HCBS IHO Waiver SOP.**

To ensure the health, safety and welfare of waiver participants, WPCS providers must be awake, alert, present during the scheduled hours of service, and immediately available to the participant. Participants who are authorized for more than 360 hours a month of combined State Plan and/or WPCS, must receive care from two or more State Plan and/or WPCS providers. A WPCS provider will not be paid to work more than 12 hours per day.

Each WPCS provider must submit a written summary with his/her signed **Time Report** to CDHS/IHO **on the 1st and 16th of every month,** describing the services they

provided to the participant, the effectiveness of any goal-oriented activities, and the participant's response to the services provided. The WPCS provider shall sign each **Time Report** and certify under penalty of perjury under the laws of the State of California, that the provisions of the services identified in the **Time Report** were provided by the WPCS provider and that the hours reported are correct.

If the provider of record is the IHSS Public Authority, Time Reports will be submitted to CDHS/IHO directly from the individual care providers and NOT through a county IHSS program.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

CDHS/IHO will not authorize direct care services or any combination of direct care and protective supervision services exceeding 24 hours of care per day under this waiver regardless of the funding source. Direct care services include State Plan services, such as personal care services, adult or pediatric day health care, In-Home Supportive Services (IHSS) Plus Waiver services, PDN, shared PDN, and/or direct care authorized by the participant's private insurance. Direct care is hands on care to support the care needs of the waiver participant. Protective supervision is observing the participant's behavior in order to safeguard the participant against injury, hazard, or accident.

Provider Specifications				
Provider Category(s):	X	Individual. List types:	X	Agency. List the types of agencies:
	Waiver Personal Care Services Provider		Employment Agency	
			Home Health Agency	
			Personal Care Agency	
			IHSS Public Authority	

Specify whether the service may be provided by:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License	Certificate	Other Standard
Waiver Personal Care Services Provider	NA	NA	County IHSS Program Standards & HCBS IHO Waiver Standards of Participation

Employment Agency	California Business License		County IHSS Program Standards & HCBS IHO Waiver Standards of Participation
Home Health Agency	Title 22, §§74659 et seq.		County IHSS Program Standards
Personal Care Agency	California Business License		County IHSS Program Standards & HCBS IHO Waiver Standards of Participation
IHSS Public Authority	**NA**	**NA**	**County IHSS Program Standards & HCBS IHO Waiver Standards of Participation**

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Unlicensed Individual	CDHS/IHO Nurse Evaluator	Every 6 months
Employment Agency	CDHS Licensing and Certification	Annually
Home Health Agency	CDHS Licensing and Certification	Annually
Personal Care Agency	CDHS Licensing and Certification	Annually
IHSS Public Authority	**State Department of Social Services**	**Annually**

Service Delivery Method				
Service Delivery Method:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Habilitation Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
X	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Habilitation Services are provided in a participant's home or an out-of-home non-facility setting designed to assist the participant in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. Habilitation services include training on the use of public transportation; personal skills development in conflict resolution; community participation; developing and maintaining interpersonal relationships; personal habits; daily living skills (cooking, cleaning, shopping, money management) and community resource awareness such as police, fire, or local services to support independence in the community. It also includes assistance with: locating, using and caring for canine and other animal companions specifically trained to provide assistance; selecting and moving into a home; locating and choosing suitable housemates; locating household furnishings; settling disputes with landlords; managing personal financial affairs; recruiting, screening, hiring, training, supervising, and dismissing personal attendants; dealing with and responding appropriately to governmental agencies and personnel; asserting civil and statutory rights through self-advocacy, and building and maintaining interpersonal relationships, including a circle of support.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
None	

Provider Specifications				
Provider Category(s)**:**	**X**	Individual. List types:	**X**	Agency. List the types of agencies:
	HCBS Registered Nurse		Home Health Agency	
	HCBS Benefit Provider		Professional Corporation	
			Non-Profit Agency	

				IHSS Public Authority	
Specify whether the service may be provided by*:*	**X**	Legally Responsible Person	**X**	Relative/Legal Guardian	
Provider Qualifications (*provide the following information for each type of provider)*:					
Provider Type:	License		Certificate	Other Standard	
HCBS Registered Nurse	BPC §§2725 et seq. Title 22, §51067; Title 16, §§1409-1419.4			HCBS IHO Waiver Standards of Participation	
HCBS Benefit Provider -Marriage Family Therapist	BPC §§4980– 4989 Title 16, §§1829-1848			HCBS IHO Waiver Standards of Participation	
HCBS Benefit Provider -Licensed Psychologist	BPC §§2909 et seq. Title 16, §§1380 et seq.			HCBS IHO Waiver Standards of Participation	
HCBS Benefit Provider -Licensed Clinical Social Worker	BPC §§4990-4998.7 Title 16, §§1870-1881			HCBS IHO Waiver Standards of Participation	
Home Health Agency – Registered Nurse	**HHA** Title 22, §§74659 et seq. **RN** BPC §§2725 et seq. Title 22, §51067; Title 16, §§1409-1419.4				
Professional Corporation	CC §13401(b)			HCBS IHO Waiver Standards of Participation	
Non-Profit Agency	Business license, appropriate for the services purchased			HCBS IHO Waiver Standards of Participation	
IHSS Public Authority	**NA**		**NA**	**County IHSS Program Standards & HCBS IHO Waiver Standards of Participation**	

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered Nurse	California Board of Registered Nursing	Biennially
Marriage Family Therapist	California Board of Behavioral Sciences	Annually
Licensed Psychologist	California Board of Psychology	Biennially
Licensed Clinical Social Worker	California Board of Behavioral Sciences	Annually
IHSS Public Authority	**State Department of Social Services**	**Annually**
Home Health Agency	CDHS Licensing and Certification	Annually
Professional Corporation	CDHS Licensing and Certification	Annually

Service Delivery Method				
Service Delivery Method:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Home Respite**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

The Home Respite benefit is intermittent or regularly scheduled temporary medical and/or non-medical care supervision provided to the participant in their own home to do the following:

1. Assist family members in maintaining the participant at home;
2. Provide appropriate care and supervision to protect the participant's safety in the absence of family members or caregivers;
3. Relieve family members from the constantly demanding responsibility of caring for a participant; and
4. Attend to the participant's medical and non-medical needs and other ADLs, which would ordinarily be performed by the service provider or family member.

The Home Respite benefit, as authorized, is to temporarily replace non-medical care that was provided to the participant by his/her legal representative/legally responsible adult(s), and/or circle of support for a scheduled period of time as previously authorized by CDHS/IHO.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

CDHS/IHO will not authorize direct care services or any combination of direct care and protective supervision services exceeding 24 hours of care per day under this waiver regardless of the funding source. Direct care services include State Plan services, such as personal care services, adult or pediatric day health care, In-Home Supportive Services (IHSS) Plus Waiver services, PDN, shared PDN, and/or direct care authorized by the participant's private insurance. Direct care is hands on care to support the care needs of the waiver participant. Protective supervision is observing the participant's behavior in order to safeguard the participant against injury, hazard, or accident.

Provider Specifications

Provider Category(s):	X	Individual. List types:	X	Agency. List the types of agencies:
	HCBS Registered Nurse		Home Health Agency	
	HCBS Licensed Vocational Nurse		Employment Agency	
	Waiver Personal Care Services Provider		Personal Care Agency	

Specify whether the service may be provided by:	X	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License	Certificate	Other Standard
Waiver Personal Care Services Provider	NA	NA	County IHSS Program Standards & HCBS IHO Waiver Standards of Participation
Employment Agency	California Business License		County IHSS Program Standards & HCBS IHO Waiver Standards of Participation
Personal Care Agency	California Business License		County IHSS Program Standards & HCBS IHO Waiver Standards of Participation
Home Health Agency	CCR Title 22, §§74659-74689		
Home Health Agency Registered Nurse	**HHA** Title 22, §74659 et seq. **RN** BPC §2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		
Home Health Agency Licensed Vocational Nurse	**HHA** Title 22, §74659 et seq. **LVN** BPC §§2859-2873.7 Title 22, §51069;		

Home Health Agency Certified Home Health Aide	**HHA** Title 22, §§74659 et seq.	**CHHA** BPC §§2725-2742 Title 22, §51067	
HCBS Registered Nurse	BPC §§2725 et seq. Title 22, §§51067; Title 16 §§1409-1419.4		HCBS IHO Waiver Standards of Participation
HCBS Licensed Vocational Nurse	BPC §§2859-2873.7 Title 22, §51069;		HCBS IHO Waiver Standards of Participation

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Unlicensed Individual	CDHS/IHO Nurse Evaluator	Every 6 months
Certified Home Health Aide	CDHS Licensing and Certification	Biennially
Licensed Vocational Nurse	California Board of Vocational Nursing and Psychiatric Technicians	Biennially
Registered Nurse	California Board of Registered Nursing	Biennially
Employment Agency	CDHS Licensing and Certification	Annually
Personal Care Services Agency	CDHS Licensing and Certification	Annually
Home Health Agency	CDHS Licensing and Certification	Annually

Service Delivery Method

Service Delivery Method:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Facility Respite**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

The Facility Respite benefit services are provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. These services are provided in an approved out-of-home location to do all of the following:

1. Provide appropriate care and supervision to protect the participant's safety in the absence of family members;
2. Relieve family members from the constantly demanding responsibility of caring for a participant; and
3. Attend to the participant's medical needs and other ADL's, which would ordinarily be the responsibility of the service provider or family member.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Provider Specifications				
Provider Category(s)**:**	☐	Individual. List types:	**X**	Agency. List the types of agencies:
			HCBS Nursing Facility	
			Nursing Facility A/B	
			Nursing Facility Subacute	
			Nursing Facility Distinct Part	

Specify whether the service may be provided by*:*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License	Certificate	Other Standard

HCBS Nursing Facility	HSC §§1250 et seq. Title 22, §§51246 et seq.		HCBS IHO Waiver Standards of Participation
NF A/B	HSC 1250 et seq. Title 22, §72301		
NF SA	HSC 1250 et seq. Title 22, §72301		
NF DP	HSC 1250 et seq. Title 22, §72301		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
HCBS Nursing Facility	CDHS Licensing and Certification	Biennially
NF A/B	CDHS Licensing and Certification	Biennially
NF SA	CDHS Licensing and Certification	Biennially
NF DP	CDHS Licensing and Certification	Biennially

Service Delivery Method

Service Delivery Method:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Community Transition Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
X	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from a licensed health care facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include: a) security deposits that are required to obtain a lease on an apartment or home; b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; e) moving expenses; f) necessary home accessibility adaptations; and g) activities to assess, arrange for, and procure needed resources. Community Transition Services are furnished only to the extent that they are reasonable and necessary. Documentation must be clearly identified in the POT that these services cannot be obtained from other sources as determined through the POT development process. Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes. The lifetime maximum allowed cost for Community Transition Services is $5,000.00. The CDHS/IHO NE will explain to the participant the guidelines of the Community Transition Services under the waiver. The use of this service will necessarily result in a reduction in other waiver services the participant may receive during the same year Community Transition Services are authorized. The participant's waiver costs must be cost neutral to the inpatient alternative. The participant should understand the possible fiscal impact of receiving this service at the time of request for the Community Transition Services.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Community Transition Services are payable up to a total lifetime maximum amount of $5,000.00.				
Provider Specifications				
Provider Category(s):	X	Individual. List types:	X	Agency. List the types of agencies:
	HCBS Registered Nurse		Home Health Agency	
	HCBS Benefit Provider		Professional Corporation	
			Non-Profit Agency	
Specify whether the service may be provided by:	X	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License	Certificate	Other Standard
HCBS Registered Nurse	BPC §§2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		HCBS IHO Waiver Standards of Participation
HCBS Benefit Provider -Marriage Family Therapist	BPC §§4980-4989 Title 16, §§1829-1848		HCBS IHO Waiver Standards of Participation
HCBS Benefit Provider -Licensed Psychologist	BPC §§2909 et seq. Title 16, §§1380 et seq.		HCBS IHO Waiver Standards of Participation
HCBS Benefit Provider -Licensed Clinical Social Worker	BPC §§4990-4998.7 Title 16, §§1870-1881		HCBS IHO Waiver Standards of Participation
Home Health Agency – Registered Nurse	**HHA** Title 22, §74659 et seq. **RN** BPC §2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		
Professional Corporation	CC §13401(b)		HCBS IHO Waiver Standards of Participation
Non-Profit Agency	Business license, appropriate for the services purchased		HCBS IHO Waiver Standards of Participation

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered Nurse	California Board of Registered Nursing	Biennially
Marriage Family Therapist	California Board of Behavioral Sciences	Annually
Licensed Psychologist	California Board of Psychology	Biennially
Licensed Clinical Social Worker	California Board of Behavioral Sciences	Annually
Home Health Agency	CDHS Licensing and Certification	Annually
Professional Corporation	CDHS Licensing and Certification	Annually
Non-Profit Agency	California Attorney General's Registry of Charitable Trusts	Annually

Service Delivery Method				
Service Delivery Method:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Environmental Accessibility Adaptations**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Environmental Accessibility Adaptations are those physical adaptations to the home, identified in the participant's POT, that are necessary to ensure the health, welfare and safety of the participant, or which enable the participant to function with greater independence in the home, and without which, the participant would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the safety and welfare of the participant. All services shall be provided in accordance with applicable State or local building codes.

All Environmental Accessibility Adaptations are subject to prior authorization by the CDHS/IHO NE. Requests for any modifications to a residence, which is not the property of the waiver recipient, shall be accompanied by written consent from the property owner for the requested modifications. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

If there is no written authorization from the owner, environmental accessibility will not be authorized or be subject to compensation for residential care providers or rental units. To the extent possible, the participant will make modifications to the residence prior to occupation. Upon commencement of the modifications, all parties will receive written documentation that the modifications are permanent, and that the State is not responsible for removal of any modification if the participant ceases to reside at a residence.

All requests for Environmental Accessibility Adaptations submitted by a provider should include the following:

1. **Primary care p**hysician's order specifying the requested equipment or service;
2. Physical or Occupational Therapy evaluation and report to evaluate the medical necessity of the requested equipment or service. This should typically come from an entity with no connection to the provider of the requested equipment or service. The Physical or Occupational Therapy evaluation and report should contain at least the following:
   a. An evaluation of the participant and the current equipment needs specific to the participant, describing how/why the current equipment does not meet the needs of the participant;
   b. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the participant. This should also include information on the ability of the participant and/or the primary caregiver to learn about and appropriately use any requested item, and
   c. Either a description of similar equipment used currently or in the past that has demonstrated to be inadequate for the participant and a description of the inadequacy.
3. A Medical Social Worker evaluation and report to evaluate other possible community resources available to provide the requested equipment or service, the availability of the other resources, and any other pertinent recommendations related to the requested equipment or service. This should include the description of the availability of Other Health Coverage (OHC) to provide for the requested equipment or service;
4. Depending on the type of adaptation or modification requested, documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the participant, including any supporting documentation describing the efficacy of the equipment. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the participant describing how and why the equipment or service meets the needs of the individual will still be necessary;
5. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and,
6. The CDHS/IHO NE will adjudicate the TAR after all requested documentation has been received and reviewed, and a home visit has been conducted by appropriate program staff to determine the suitability of any requested equipment or service.

The lifetime maximum allowed cost for Environmental Accessibility Adaptations is

$5,000.00. It is the responsibility of the CDHS/IHO NE to explain to the participant the guidelines of the Environmental Accessibility Adaptation services under the waiver. The use of this service may result in a reduction in other waiver services the participant may receive during the same year that Environmental Accessibility Adaptations service is authorized. The participant waiver costs must be cost neutral to the individual's cost limit. The participant should understand at the time of the request for Environmental Accessibility Adaptation service, that in accessing this service, if the cost of the service exceeds the individual's cost limit it may jeopardize his/her ability to remain on the waiver and may affect the ability to access other services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Environmental Accessibility Adaptation services are payable up to a total lifetime maximum amount of $5,000.00. The only exceptions to the $5,000.00 total maximum are if:

1. The recipient's place of residence changes; or
2. In the opinion of the CDHS/IHO NE, and based upon review of appropriate documentation, the waiver participant's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare and safety of the participant, or are necessary to enable the participant to function with greater independence in the home and without which, the recipient would require institutionalization.

Provider Specifications

Provider Category(s):	X	Individual. List types:	X	Agency. List the types of agencies:
		Building Contractor		Non-Profit Agency
		Private Business		Durable Medical Equipment (DME) Provider

Specify whether the service may be provided by:	X	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License	Certificate	Other Standard
Durable Medical Equipment (DME) Provider	W&I 14043.15, 14043.2, 14043.25, 14043.26 Title 22, §51000.30(B)(3), §51000.55,		Business license appropriate for the services purchased.

	§§51006(a)(1), (a)(2), (a)(3), (a)(5)		
Building Contractor	Contractor or business license, appropriate for the services purchased		
Non-Profit Agency	Business license, appropriate for the services purchased		HCBS IHO Waiver Standards of Participation
Private Business	Business license, appropriate for the services purchased		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Durable Medical Equipment (DME) Provider	CDHS, Food and Drug Division	Annually
Non-Profit Agency	California Attorney General's Registry of Charitable Trusts	Annually
Building Contractor	CDHS/IHO Nurse Evaluator	Prior to the authorization of requested services.
Private Individual	CDHS/IHO Nurse Evaluator	Prior to the authorization of requested services.

Service Delivery Method				
Service Delivery Method:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Family Training**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Family Training services are training and counseling for families of waiver participants. For purposes of this service, "family" is defined as persons who live with or provide care to a participant served on the waiver (may include a parent, spouse, children, relatives, foster family, in-laws or other responsible persons who agree to act as an uncompensated caregiver in the absence of a waiver service provider). "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the POT, how to care for the participant in the absence of the paid care providers and includes updates as necessary to safely maintain the participant at home. All family training must be included in the participant's written POT.

Family Training services may only be provided by a RN. Upon request from the participant, his/her family, participant's **primary care** physician, provider of services, or the CDHS/IHO NE for family training, the provider of service, must document the training that is needed and the process to meet the need. The provider of the service will submit the documentation and the request to provide family training to the CDHS/IHO NE. The CDHS/IHO NE will review the documentation and authorize when medically necessary to ensure the health and safety of the participant. Upon completion of the training, the provider will submit to the CDHS/IHO NE documentation of the results of the training.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

None

Provider Specifications				
Provider Category(s)**:**	**X**	Individual. List types:	**X**	Agency. List the types of agencies:
	HCBS Registered Nurse		Home Health Agency	

Specify whether the service may be provided by:	**X**	Legally Responsible Person	**X**	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License	Certificate	Other Standard
HCBS Registered Nurse	BPC §§2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		HCBS IHO Waiver Standards of Participation
Home Health Agency – Registered Nurse	**HHA** Title 22, §74659 et seq. **RN** BPC §2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered Nurse	California Board of Registered Nursing	Biennially
Home Health Agency	CDHS Licensing and Certification	Annually

Service Delivery Method

Service Delivery Method:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Personal Emergency Response Systems**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

The Personal Emergency Response Systems (PERS) is a 24-hour emergency assistance electronic device that enables certain participants at high risk of institutionalization to secure help in an emotional, physical, or environmental emergency. PERS services are limited to participants who live alone, are alone for significant parts of the day, or have no regular caregiver for extended periods, and would otherwise require routine supervision.

The PERS is connected to the person's telephone and programmed to signal a response center once a "help" button is activated. The participant may wear a portable "help" button permitting greater mobility. The response center is staffed with trained professionals who have access to the participant's profile and critical information. PERS staff immediately attempts to contact the participant to determine if an emergency exists. If one does exist, the PERS staff contacts local emergency response services to request assistance.

The immediate response to a participant's request for assistance can help prevent unnecessary institutionalization of a waiver participant. PERS services will only be provided as a waiver service to a participant residing in a non-licensed environment.

PERS are individually designed to meet the needs and capabilities of the participant. The following services are allowed:

1. 24-hour answering/paging;
2. Beepers;
3. Med-alert bracelets;
4. Intercoms;
5. Life-lines;
6. Fire/safety devices, such as fire extinguishers and rope ladders;
7. Monitoring services;
8. Light fixture adaptations (blinking lights, etc.);

9. Telephone adaptive devices not available from the telephone company; and
10. Other electronic devices/services designed for emergency assistance.

All types of PERS, described above, shall meet applicable standards of manufacture, design, and installation. Repairs and maintenance of such equipment shall be performed by the manufacturer's authorized dealers whenever possible. Prior authorization for PERS services must be obtained by the waiver service provider from the CDHS/IHO NE.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s):	☐	Individual. List types:	X	Agency. List the types of agencies:
	Private Business		Non-Profit Agency	
			Professional Corporation	
			Durable Medical Equipment (DME) Provider	
			Home Health Agency	

Specify whether the service may be provided by:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License	Certificate	Other Standard
Durable Medical Equipment (DME) Provider	W&I 14043.15, 14043.2, 14043.25, 14043.26 Title 22, §51000.30(B)(3), §51000.55, §§51006(a)(1), (a)(2), (a)(3), (a)(5)		Business license appropriate for the services purchased.
Non-Profit Agency	Business license, appropriate for the services purchased		HCBS IHO Waiver Standards of Participation
Professional Corporation	CC §13401(b)		
Home Health Agency	**HHA** Title 22,		

	§74659 et seq. **RN** BPC §2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		
Private Business	Business license, appropriate for the services purchased		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Durable Medical Equipment (DME) Provider	CDHS, Food and Drug Division	Annually
Marriage Family Therapist	California Board of Behavioral Sciences	Annually
Licensed Psychologist	California Board of Psychology	Biennially
Licensed Clinical Social Worker	California Board of Behavioral Sciences	Annually
Private Individual	CDHS/IHO Nurse Evaluator	Prior to the authorization of requested services
Non-Profit Agency	California Attorney General's Registry of Charitable Trusts	Annually
Professional Corporation	CDHS Licensing and Certification	Annually

Service Delivery Method

Service Delivery Method:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Personal Emergency Response Systems – Installation and Testing**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
The Personal Emergency Response System (PERS) installation and testing service is for installation and testing of a PERS for individuals at high risk of institutionalization to secure help in the event of an emergency. Authorization is limited to individuals who live alone, who are alone for significant parts of the day, have no regular caregiver for extended periods, and who would otherwise require routine supervision.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
None	

Provider Specifications				
Provider Category(s)**:**	☐	Individual. List types:	**X**	Agency. List the types of agencies:
	Private Business		Non-Profit Agency	
			Professional Corporation	
			Durable Medical Equipment (DME) Provider	
			Home Health Agency	
Specify whether the service may be provided by*:*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License	Certificate	Other Standard
Durable Medical Equipment (DME) Provider	W&I 14043.15, 14043.2, 14043.25, 14043.26 Title 22, §51000.30(B)(3),		

	§51000.55, §§51006(a)(1), (a)(2), (a)(3), (a)(5)		
Non-Profit Agency	Business license, appropriate for the services purchased		
Professional Corporation	CC §13401(b)		
Home Health Agency	**HHA** Title 22, §74659 et seq. **RN** BPC §2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		
Private Business	Business license, appropriate for the services purchased		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Durable Medical Equipment (DME) Provider	CDHS, Food and Drug Division	Annually
Private Individual	CDHS/IHO Nurse Evaluator	Prior to the authorization of requested services.
Marriage Family Therapist	California Board of Behavioral Sciences	Annually
Licensed Psychologist	California Board of Psychology	Biennially
Licensed Clinical Social Worker	California Board of Behavioral Sciences	Annually
Non-Profit Agency	California Attorney General's Registry of Charitable Trusts	Annually
Professional Corporation	CDHS Licensing and Certification	Annually

Service Delivery Method				
Service Delivery Method:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Private Duty Nursing, includes shared services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Private Duty Nursing services are individual and continuous care (in contrast to part-time or intermittent care) provided by a licensed nurse or a certified home health aide under a home health agency within the scope of state law. Services are provided to a waiver participant in his/her home or home-like environment. Shared PDN services are provided to two participants who live at the same residence. Shared PDN services are provided only on request and agreement of the involved participants and/or his/her authorized representative(s). A HCBS RN provides supervision and monitoring of PDN or Shared PDN services if provided by an HCBS LVN.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
CDHS/IHO will not authorize direct care services or any combination of direct care and protective supervision services exceeding 24 hours of care per day under this waiver regardless of the funding source. Direct care services include State Plan services, such as personal care services, adult or pediatric day health care, In-Home Supportive Services (IHSS) Plus Waiver services, PDN, shared PDN, and/or direct care authorized by the participant's private insurance. Direct care is hands on care to support the care needs of the waiver participant. Protective supervision is observing the participant's behavior in order to safeguard the participant against injury, hazard, or accident.	

Provider Specifications				
Provider Category(s)**:**	**X**	Individual. List types:	**X**	Agency. List the types of agencies:
	HCBS Waiver LVN		Home Health Agency	
	HCBS Waiver RN		HCBS Nursing Facility	
Specify whether the service may be provided by*:*	**X**	Legally Responsible	**X**	Relative/Legal Guardian

		Person	

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License	Certificate	Other Standard
HCBS Nursing Facility	HSC §§1250 et seq. Title 22, §§51246 et seq.		HCBS IHO Waiver Standards of Participation
HCBS Registered Nurse	BPC §§2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		HCBS IHO Waiver Standards of Participation
HCBS Licensed Vocational Nurse	BPC §§2859-2873.7 Title 22, §51069		HCBS IHO Waiver Standards of Participation
Home Health Agency – Registered Nurse	**HHA** Title 22, §74659 et seq. **RN** BPC §2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		
Home Health Agency Licensed Vocational Nurse	**HHA** Title 22, §§74659-74689 **LVN** BPC §§2859-2873.7 Title 22, §51069;		
Home Health Agency Certified Home Health Aide	**HHA** Title 22, §§74659 et seq.	**CHHA** BPC §§1736.1-1736.6	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Congregate Living Health Facility	CDHS Licensing and Certification	Annually
Home Health Agency	CDHS Licensing and Certification	Annually
Registered Nurse	California Board of Registered Nursing	Biennially
Licensed Vocational Nurse	California Board of Vocational Nursing and Psychiatric	Biennially

	Technicians			
Certified Home Health Aide	CDHS Licensing and Certification		Annually	
Service Delivery Method				
Service Delivery Method:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Transitional Case Management**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Transitional Case Management (TCM) services are provided to transition a Medi-Cal waiver eligible individual from a health care facility to a home and community-based setting. TCM providers will have direct contact with the participant, his/her circle of support and the participant's primary **care** physician to obtain information that will allow the TCM provider to coordinate services such as housing, equipment, supplies, or transportation that may be necessary to leave a health care facility. TCM services may be provided up to 180 days prior to discharge from a health care facility. All TCM services provided will be billed against the waiver on the date of waiver enrollment. If the participant should decease before discharge, the TCM services provided may be claimed as an administrative expense under the State Plan.

TCM service will include an evaluation of the participant's medical and non-medical care needs, circle of support, home setting, and funding sources to support the participant's choice to transition from the facility to a home and community-based setting. The TCM provider will coordinate the transition of services with the participant's waiver case manager and/or waiver service coordinator, when appropriate, upon the individual's enrollment to the waiver.

Requests for this service shall be accompanied by a POT that includes: the participant's medical and non-medical care needs, and plan on how the individual's needs are met.

The use of this service will necessarily result in a reduction in other waiver services the participant may receive during the same year that Transitional Case Management services are authorized. The participant waiver costs must be cost neutral to the inpatient alternative. The participant should understand the possible fiscal impact of receiving this service at the time of request for Transitional Case Management services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

TCM services may be provided up to 180 days prior to discharge from health care facility. These services will be provided before the individual's enrollment in the waiver.

Provider Specifications				
Provider Category(s):	X	Individual. List types:	X	Agency. List the types of agencies:
	HCBS Benefit Provider		Home Health Agency	
	HCBS Waiver RN		Professional Corporation	
			Non-Profit Agency	

Specify whether the service may be provided by:	X	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

HCBS Registered Nurse	BPC §§2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		HCBS IHO Waiver Standards of Participation
HCBS Benefit Provider -Marriage Family Therapist	BPC §§4980– 4989 Title 16, §§1829-1848		HCBS IHO Waiver Standards of Participation
HCBS Benefit Provider -Licensed Psychologist	BPC §§2909 et seq. Title 16, §§1380 et seq.		HCBS IHO Waiver Standards of Participation
HCBS Benefit Provider -Licensed Clinical Social Worker	BPC §§4990-4998.7 Title 16, §§1870-1881		HCBS IHO Waiver Standards of Participation
Home Health Agency – Registered Nurse	**HHA** Title 22, §74659 et seq. **RN** BPC §2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		
Professional Corporation	CC §13401(b)		HCBS IHO Waiver Standards of Participation
Non-Profit Agency	Business license, appropriate for the services purchased		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Registered Nurse	California Board of Registered Nursing	Biennially
Marriage Family Therapist	California Board of Behavioral Sciences	Annually
Licensed Psychologist	California Board of Psychology	Biennially
Licensed Clinical Social Worker	California Board of Behavioral Sciences	Annually
Home Health Agency	CDHS Licensing and Certification	Annually
Professional Corporation	CDHS Licensing and Certification	Annually
Non-Profit Agency	California Attorney General's Registry of Charitable Trusts	Annually

Service Delivery Method				
Service Delivery Method:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Medical Equipment Operating Expenses**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Medical Equipment Operating Expenses are services necessary to prevent reinstitutionalization for waiver participants who are dependent upon medical technology. Medical Equipment Operating Expenses must be described in the participant's POT. Medical Equipment Operating Expenses are limited to utility costs directly attributable to operation of life sustaining medical equipment in the participant's place of residence. For purposes of this waiver service, "life sustaining medical equipment" is defined as mechanical ventilation equipment and positive airway pressure equipment, suction machines, feeding pumps, and infusion equipment. Notwithstanding this definition, in the event a specific medical need is identified and Medical Equipment Operating Expenses are requested in the POT, CDHS/IHO will evaluate the request for this service and may grant exceptions to this definition.

The waiver service provider may submit a request for the authorization of this service to CDHS/IHO for evaluation of the request. After the request has been approved, the waiver service provider may bill Medi-Cal for this service. Upon the provider's receipt of payment, the provider will reimburse the monies to the participant.

In order to calculate the cost per unit of time, the authorization for waiver Medical Equipment Operating Expenses includes consideration of the type of equipment and frequency of use. Cost factors to operate electrical equipment are supplied by local utility companies and are based on a consideration of the equipment's size and voltage and amperage requirement.

The waiver participant's case manager is responsible for notifying the local utility providers that the HCBS IHO Waiver participant is an individual dependent upon life sustaining medical equipment. Documentation indicating that local utilities have been notified shall be kept in the participant's case record, and updated and revised when necessary by the CDHS/IHO NE.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The minimum monthly claim for utility coverage reimbursement is $20.00, the

maximum is $75.00.				
Provider Specifications				
Provider Category(s)**:**	**X**	Individual. List types:	**X**	Agency. List the types of agencies:
	HCBS Benefit Provider		Home Health Agency	
	HCBS Waiver RN		Professional Corporation	
			Non-Profit Agency	

Specify whether the service may be provided by*:*	**X**	Legally Responsible Person	**X**	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License	Certificate	Other Standard
HCBS Registered Nurse	BPC §§2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		HCBS IHO Waiver Standards of Participation
HCBS Benefit Provider -Marriage Family Therapist	BPC §§4980– 4989 Title 16, §§1829-1848		HCBS IHO Waiver Standards of Participation
HCBS Benefit Provider -Licensed Psychologist	BPC §§2909 et seq. Title 16, §§1380 et seq.		HCBS IHO Waiver Standards of Participation
HCBS Benefit Provider -Licensed Clinical Social Worker	BPC §§4990-4998.7 Title 16, §§1870-1881		HCBS IHO Waiver Standards of Participation
Home Health Agency – Registered Nurse	**HHA** Title 22, §74659 et seq. **RN** BPC §2725 et seq. Title 22, §51067; Title 16, §1409-1419.4		
Professional Corporation	CC §13401(b)		HCBS IHO Waiver Standards of Participation
Non-Profit Agency	Business license, appropriate for the services purchased		

Private Business			
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Registered Nurse	California Board of Registered Nursing		Biennially
Marriage Family Therapist	California Board of Behavioral Sciences		Annually
Licensed Psychologist	California Board of Psychology		Biennially
Licensed Clinical Social Worker	California Board of Behavioral Sciences		Annually
Private Individual	CDHS/IHO Nurse Evaluator		Prior to the authorization of requested services
Home Health Agency	CDHS Licensing and Certification		Annually
Professional Corporation	CDHS Licensing and Certification		Annually
Non-Profit Agency	California Attorney General's Registry of Charitable Trusts		Annually

Service Delivery Method				
Service Delivery Method:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed
None.				

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above*.
X	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above*.

Enrollment in the IHO HCBS Waiver is dependent on an individual waiver participant accepting their current level expenditures for waiver and state plan services that meets their current needs to remain safely in the home and community and are described on their current POT_as their prospective individual cost limit.

(a) The HCBS IHO Waiver does not impose limits on waiver services; waiver participants can chose waiver services and providers best suited to meet their needs.

(b) The individual cost limit is established using the participant's established level of expenditures as described on their current POT and meet their current needs at the time of their assessment for enrollment in the HCBS IHO Waiver.

(c) A participant's individual cost limit can be adjusted over the course of the waiver period based on medical necessity documented in the **primary care** physician signed POT. Any increase in the participant's individual cost limit must meet their current assessed needs and described on the participant's current POT.

(d) A waiver participant is periodically reevaluated for continued enrollment in the HCBS IHO Waiver. During the reevaluation visit, the CDHS/IHO NE reviews with the participant and/or their legal representative/legally responsible adult(s), and/or their circle of support the POT and their waiver program.

(e) The CDHS/IHO NE assesses the waiver participant, establishing a level of case management, described in Appendix B-6(g). The case management acuity level establishes the frequency of CDHS/IHO NE home visits and level oversight.

(f) The initial individual cost limit is based on the level of waiver expenditure when transitioned to the HCBS IHO waiver program. The participant is notified of changes to their individual cost limit in writing. A NOA letter is sent to the participant describing the authorized change in the amount of the limit.

☐ **Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above*.

☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*
☐	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals:

X	Registered nurse (RN), licensed to practice in the State
☐	Licensed practical or vocational nurse (LVN), acting within the scope of practice under State law
X	Licensed physician (M.D. or D.O.)
X	Case Manager (qualifications specified in Appendix C-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

b. Service Plan Development Safeguards. *Select one:*

☐	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
X	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:
	An HCBS IHO Waiver case management provider who meets the service

requirements set forth in Appendix C-3 and in the HCBS IHO Waiver Standards of Participation may provide other waiver services described in the Plan of Treatment (POT). The POT must be reviewed and signed by the **primary care** physician overseeing the participant's home program.

The **primary care** physician-signed POT must be current and updated at least every 180 days, or more often when the participant's health status and needs change. The waiver case manager is responsible for submitting the latest **primary care** physician-signed POT with each Treatment Authorization Request (TAR) for waiver services.

Before approving the initial authorization or reauthorization for waiver services, the CDHS/IHO NE reviews the POT to determine that the requested waiver services are medically necessary and that the amount, frequency, and duration of each service is included, as well as the provider type. The POT must also document that the participant and/or his/her legal representative/legally responsible adult(s) participated in the development of the POT and was informed of his/her free choice to select qualified providers.

During the initial and ongoing home visits, the CDHS/IHO NE discusses with the participant and/or his/her legal representative/legally responsible adult(s) his/her right to freely choose a waiver provider to provide services described in the POT. If the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support requests assistance identifying providers of waiver services, the CDHS/IHO NE will give the participant and/or his/her legal representative/legally responsible adult(s) the Menu of Health Services (MOHS) and a list of local HCBS waiver providers. The MOHS provides information on the different types of waiver services and provider types, and the cost of each service.

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative/legally responsible adult, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) The CDHS/IHO NE provides the waiver participant, and/or his/her legal representative/legally responsible adult(s), and/or circle of support with information on the purpose of the POT and encourages them to participate in identifying his/her needs, services, and providers to support and ensure the safety of his/her home program. The information is provided verbally

at the initial and ongoing face-to-face home visits, as well as in writing through the HCBS Informing Notice and MOHS. During the ongoing home visits, the CDHS/IHO NE reviews the POT with the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support to ensure the POT accurately reflects the participant's identified care needs, type and duration of services, and providers of the service.

The CDHS/IHO NE is available to assist the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support with information on the State plan and waiver services that can meet his/her identified needs. Participants are encouraged to select waiver providers that are best suited to meet his/her needs, taking into account experience providing direct care services in the home, availability, hours of service, and cultural and linguistic competencies.

The CDHS/IHO NE provides training to HCBS waiver providers, who assist the participant in the development of his/her POT, on the waiver requirement to include the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support in the development of the POT. The provider receives this information verbally during the provider visit and in the HCBS Informing Notice that is mailed to the HCBS waiver provider.

(b) Beginning with the application for waiver services and throughout the development of the POT, the participant and/or his/her legal representative/legally responsible adult and/or circle of support are provided with the opportunity and encouraged to involve individuals of his/her choice in the development of the POT. The "Medi-Cal Home and Community-Based Services Waiver Informing Notice" informs the participant and/or his/her legal representative/legally responsible adult of his/her authority in determining who can assist them in selecting and identifying waiver services and providers. The Informing Notice includes a complete description of the participant, his/her primary caregivers, the primary care physician, HCBS waiver service providers, and CDHS/IHO' roles and responsibilities in the development and implementation of the POT.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The waiver case manager is responsible for developing the POT. A waiver case manager can be:

- A RN licensed to practice in the State of California, who is employed by a Home Health Agency or who is under the direction of a licensed physician.
- A Physician licensed to practice in the State of California who is the participant's **primary care** physician.
- A Marriage and Family Therapist (MFT), Licensed Clinical Psychologist, Licensed Clinical Social Worker (LCSW).
- A professional corporation that employs MFTs, Licensed Clinical Psychologists, and/or LCSWs.
- A non-profit agency that employs MFTs, Licensed Clinical Psychologists, LCSWs or individuals with a Baccalaureate degree or higher in Clinical Social Worker, Social Welfare, Psychology, Marriage and Family Therapy or Gerontology.

The participant's primary care physician must participate in the development of the POT.

CDHS/IHO policies and procedures require that the participant's waiver case manager include the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support in identifying the participant's care needs, waiver services, and providers in the development of the POT.

The participant's waiver case manager is responsible for completing the initial POT and updating it at least every 180 days thereafter. If after the

completion of the initial POT it is determined that the POT does not meet the participant's needs due to significant changes in the participant's condition, the waiver case manager, consulting with the **primary care** physician, must submit an updated or revised **primary care** physician-signed POT to the CDHS/IHO NE. "Significant changes" are changes that suggest the need to modify the POT, such as changes in the participant's health status, home setting, or availability of waiver providers.

The CDHS/IHO NE monitors the timeliness of the POT. Waiver service providers are required to submit a copy of the current **primary care** physician-signed POT with each request for authorization of waiver services.

(b) Waiver case managers can use the "Medi-Cal Operations, Home and Community-Based Services, Plan of Treatment" or the CMS-485 Home Health Plan of Care for the POT.

The POT must include the participant's demographic information; treating and primary care physician information; medical information and diagnosis; HCBS waiver program and LOC; all required waiver services, including amount and frequency, and waiver service provider type; state plan services; durable medical equipment required; medication plan; nutritional requirements; the treatment plan for the home program; the participant's functional limitations; permitted activities; mental status; medical supplies; ongoing therapies and therapy referrals; treatment goals, including rehabilitation potential; and training needs for the participant and family.

The waiver case manager completes the POT summarizing the status of the participant during the previous POT period and the effectiveness of the services provided. The participant, and/or his/her legal representative/legally responsible adult(s), the **primary care** physician and all providers of waiver services sign the completed POT.

The CDHS/IHO NE reviews the completed POT to verify the participant's care needs, the frequency of waiver and state plan services, providers, and the participant's goals. Back-up systems are also identified. The CDHS/IHO NE's review of the POT is conducted during the initial request for HCBS IHO Waiver services, during the reevaluation of the participant's LOC, at the annual provider visit, and with each request for waiver services. The CDHS/IHO NE may ask for additional documentation supporting the medical necessity of the services described in the POT. Any necessary or suggested revisions of the POT are discussed with the waiver service providers, the **primary care** physician, and participant and/or legal representative/legally responsible adult(s)

and/or circle of support. Modifications to the POT are made only with approval of the participant and/or his/her legal representative/legally responsible adult and the **primary care** physician.

(c) The CDHS/IHO NE provides information to the participant and/or his/her legal representative(s), and/or circle of support on the HCBS IHO Waiver and available provider types. This information is provided verbally during the initial and subsequent home visits, and in writing though the Menu of Health Services (MOHS). The MOHS lists all the waiver services and provider types available to the participant. The MOHS is a planning instrument that is used by the participant and/or his/her legal representative/legally responsible adult, circle of support and CDHS/IHO NE in the development of a home care program, and to ensure the home program meets the HCBS IHO Waiver cost neutrality requirements. The participant and/or his/her legal representative/legally responsible adult(s) and/or his/her circle of support are encouraged to select the waiver service best suited to meet his/her needs during the completion of the MOHS. The participant and/or his/her legal representative/legally responsible adult(s), and/or circle of support are advised to contact, by telephone or in writing, the CDHS/IHO NE when they have questions regarding waiver services and/or providers.

(d) The POT process is designed to document the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support goals for successfully living at home in the community. Waiver participants are encouraged to participate in the development of the POT, choosing waiver services, providers, and treatment options that will assist them in meeting the stated goals. The participant and/or his/her legal representative/legally responsible adult(s) and waiver service providers responsible for the services specified in the plan must sign the completed POT. The CDHS/IHO NE reviews the effectiveness of meeting the goals described in the POT during the LOC reevaluation home visit.

(e) The waiver case manager is primarily responsible for assisting the participant with coordination of waiver and state plan services. The waiver case manger regularly updates the POT, documenting changes in the participant's health status and identifying waiver and non-waiver services needed for the participant to remain safely at home. The waiver case manager can assist the participant and/or his/her legal representative/legally responsible adult(s) and/or members of the circle of support identify providers, or other necessary services.

The CDHS/IHO NE can also assist the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support and

waiver case manager to identify local resources, provided by non-governmental organizations or state and local government agencies, for transportation, housing, and nutrition services.

(f) The POT requires the waiver case manager to identify waiver services, waiver providers, and the amount and frequency of waiver services. The waiver case manager is responsible for making certain that services are provided in accordance with the POT. The CDHS/IHO NE reviews the POT while conduct the LOC reevaluation. During the reevaluation, the CDHS/IHO NE reviews the POT with the participant and/or his/her legal representative/legally responsible adult(s) and/or members of the circle of support to identify any problems in the home care program. The waiver case manager is required to be present during the participant's scheduled reevaluation. Annually, the CDHS/IHO NE conducts the provider visit with the waiver case manager to review the participant case record and the participant's home program, including implementation of the elements of the POT. The CDHS/IHO NE, together with the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support, and waiver case manager prepares a plan of correction for issues identified during the reevaluation or the annual provider visit.

(g) After the completion of the initial POT, if it is determined that the POT does not meet the participant's needs due to significant changes in the participant's condition, the waiver case manager, consulting with the **primary care** physician, must submit an updated or revised POT to the CDHS/IHO NE. "Significant changes" are changes that suggest the need to modify the POT such as changes in the participant's health status, home setting, or availability of waiver providers.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The POT documents the waiver case manager's nursing evaluation and proposed interventions enabling the participant to live safely at home in the community. The CDHS/IHO NE reviews the POT, taking into account the participant's medical condition and care need(s), and verifies the POT is signed by the waiver case manager service provider and the responsible **primary care** physician. The **primary care** physician's signature is evidence that the primary care physician has reviewed the POT, agrees that it addresses the participant's health care needs so that he/she can live safely at home in the

community.

The POT is developed based on information obtained from the nursing evaluation and the home safety evaluation. The latter demonstrates that the participant's home environment is safe and conducive to the successful implementation of a home and community-based services program. It includes an evaluation of risk factors affecting the participant's health and safety (e.g. sufficient care providers trained in the participant's care needs, effective back-up plan, evaluation for abuse, neglect and exploitation). Identified conditions that may affect the participant's health, welfare, and/or safety require the waiver case manager to develop a plan of correction and provide evidence that the conditions are corrected. An approved POT will include the following information:

- Assurance that the area where the participant will be cared for can accommodate the use, maintenance, and cleaning of all medical devices, equipment, and storage supplies necessary to maintain the participant in the home in comfort and safety, and to facilitate the nursing care required;
- Assurance that primary and back-up utility, communication, and fire safety systems and devices are available, installed, and in working order, including grounded electrical outlets, smoke detectors, fire extinguisher, and telephone services;
- Evidence that local emergency and rescue services and utility services have been notified that a person with special needs resides in the home;
- Assurance that all medical equipment, supplies, primary and back-up systems, and other services and supports, are in place and available in working order, or have been ordered and will be in place at the time the participant is placed in the home;
- Documentation that the participant is not subjected to abuse, neglect, or exploitation and is knowledgeable of his/her rights and who to contact if incidents occur; and
- Documentation that the caregivers are knowledgeable of the care needs of the participant.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Participants receiving services through the HCBS IHO Waiver can select any Medi-Cal provider who is willing to provide State Plan or waiver services and is qualified and enrolled as a waiver provider. The CDHS/IHO NE provides

the participant and/or his/her legal representative/legally responsible adult(s) and/or members of his/her circle of support with a list of current HCBS waiver providers and information on how a non-HCBS waiver provider can enroll as a waiver provider. Additionally, the CDHS/IHO NE provides the participant and/or his/her legal representative/legally responsible adult(s) with the MOHS, which includes the provider types authorized to provide approved waiver services.

Waiver participants are encouraged to identify providers of waiver services that can best meet his/her needs. Factors considered should include a provider's experience, abilities, and availability to provide services in a home and community-based setting, as well as the ability to work with the participant's other caregivers, the primary care physician, and the CDHS/IHO NE. When needed, the CDHS/IHO NE can assist the participant and/or legal representative/legally responsible adults in locating waiver service providers.

g. 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 in accordance with 42 CFR §441.301(b)(1)(i):

The CDHS/IHO NE is responsible for approving the POT. A current POT must be submitted to CDHS/IHO at the initial waiver enrollment and with each TAR for authorization of waiver services. The CDHS/IHO NE reviews the POT with the participant and/or legal representative/legally responsible adult(s), and/or circle of support, during each home visit and with the HCBS waiver providers during the annual visit. POTs not meeting the HCBS IHO Waiver standards are returned to the waiver case manager with instructions regarding needed revisions or additional information required. The revised POT must be sent to the participant's **primary care** physician for review and signature. Enrollment in the HCBS IHO Waiver or authorization for requested waiver services will not be completed until the POT is revised and accurately reflects the participant's needs, services, providers, goals, and identifies and corrects safety issues.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

○	Every three months or more frequently when necessary
X	Every six months or more frequently when necessary
○	Every twelve months or more frequently when necessary

○	Other schedule :
	Medicaid agency
☐	Operating agency
X	Case manager
☐	Other :

Appendix D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring**. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed

(a) The CDHS/IHO NE and waiver case manager are responsible for monitoring the implementation of the POT, and ensuring that it accurately reflects the participant's care needs, and that the participant is receiving the described waiver services.

(b) The CDHS/IHO NE and waiver case manager ensure that waiver services are furnished in accordance with the POT by maintaining regular contact with the participant and/or his/her legal representative/legally responsible adult and/or circle of support. Contact includes home visits and telephone calls. The waiver case manager is responsible for regularly apprising the CDHS/IHO NE of the participant's status and reporting any unforeseen issues or problems that could negatively affect the participant.

The waiver case manager is responsible for maintaining participant case notes documenting the participant's health status and identified problems and issues. The waiver case manager is responsible for documenting plans of correction and resolution of identified problems or issues regarding implementation of the participant's POT or his/her health and welfare. The CDHS/IHO NE regularly reviews the waiver case manager's case notes and documentation to ensure that any plan of correction was completed with appropriate follow-up. During regularly scheduled meetings with the participant and/or his/he legal representative/legally responsible adult(s) and/or circle of support, the CDHS/IHO NE asks if they are satisfied with the plan of correction and resolution.

At the home visit, the CDHS/IHO NE reviews the POT with the participant and/or his/her legal representative/legally responsible adult(s) and/or members of his/her circle of support to:

- Verify the participant's POT is current and signed by the **primary care** physician. Copies of the current and past POTs are filed in the participant's case record.
- Verify the participant is receiving the services described in the POT, review the POT with the participant and/or his/her legal

representative/legally responsible adults and/or members of his/her circle of support and discuss the recommendations for waiver and non-waiver services and providers of services.

- Ensure the POT meets the participant's health care needs and personal goals. During the on-site home visit the CDHS/IHO NE attempts to determine if the participant is receiving all the services identified in the POT, whether the participant is satisfied with the care being delivered, and if the participant is receiving the services needed to remain safely at home.
- Ensure a complete and accurate written medical record, including diagnoses, complete evaluation, treatment plan, and prognosis is available when determining the need for the HCBS waiver services described in the POT.
- Determine that waiver and non-waiver State Plan services provided do not exceed the waiver cost neutrality.
- Review the back-up plan in the event a provider is not available. The CDHS/IHO NE can assist the participant and/or his/her legal representative/legally responsible adults and/or members of his/her circle of support in identifying providers and community resources as part of his/her back-up plan.
- Document the participant and his/her legal representative/legally responsible adult are evaluated for and instructed on how to recognize and report abuse, neglect and exploitation. The POT reflects any risk for abuse, neglect and exploitation and how incidents will be prevented.
- Ensure the written home safety evaluation has been completed and all identified issues are addressed on the POT. The home safety evaluation assesses participant accessibility, structural barriers, utilities, evacuation plans, and communication and fire safety systems and devices.
- Document the participant's home is safe.

Identified problems or deficiencies the POT are discussed with the waiver case manager, the participant, and/or his/her legal representative/legally responsible adults and/or members of his/her circle of support. Corrections must be made to the POT, which is reviewed and approved by the participant's **primary care** physician, before additional HCBS waiver services and/or continued enrollment in the HCBS IHO Waiver can be authorized by CDHS/IHO. Health and safety issues described in the POT are documented using the Event/Issue Report and included in the participant's case record.

(c) On enrollment into the HCBS IHO Waiver, the intake CDHS/IHO NE

reviews the initial POT with the participant and/or his/her legal representative/legally responsible adults and/or circle of support. Ninety (90) days after waiver enrollment and the start of waiver services, the CDHS/IHO NE case manager conducts a home visit to assess how the participant is coping. The CDHS/IHO NE reviews the POT with the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support to verify that services are provided as described. Subsequent scheduled LOC reevaluation visits include a review of the POT with the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support to determine if the POT continues to meet the participant's needs.

The level of case management acuity system is used by the CDHS/IHO NE to determine the frequency of home visits based upon the participant's risk factors and the complexity of his/her home program. The system identifies four levels of case management of increasing acuity. The level of acuity is reevaluated at each home visit and upon changes to the participant's medical care needs, support system, and provider types. The level of case management acuity system is described in detail in Appendix B, at item B-6(g)

Between the scheduled home visits, the CDHS/IHO NE maintains contact with the participant and the HCBS waiver case manager. A record of the interim contact is documented in the running record section of the participant's case record. Based on interim contact reports and/or information received from the participant or the waiver case manager, the CDHS/IHO NE may request the POT be updated to reflect changes in the participant's care needs, waiver providers, and/or the delivery of waiver services. The HCBS waiver case manager is responsible for submitting the revised POT to the CDHS/IHO NE for review and approval.

b. Monitoring Safeguards. *Select one:*

X	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

X	**Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
○	**No.** This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

○	**Yes.** The State requests that this waiver be considered for Independence Plus designation.
X	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (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 waiver's approach to participant direction.

HCBS IHO Waiver participants or their legal representative have the opportunity to hire and dismiss licensed and unlicensed providers who under the direction of the participant or legal representative can provide waiver services as described in Appendix C of this application. The ability to hire, dismiss and direct the services of the individual waiver providers supports:

- freedom of choice in the provider of waiver services;
- flexibility in scheduling the services to meet the participant's needs;
- continuity of care; and
- ability to direct the services that meet the participant's needs.

CDHS/IHO provides information on the availability of this option to the participant or legal representative at the face-to-face intake assessment and reassessment visits. CDHS/IHO advises the participant or legal representative on the roles and responsibilities for the participant or legal representative, **primary care** physician who oversees the participants home program, CDHS/IHO and the provider. Upon request CDHS/IHO will provide the participant, legal representative and potential wavier provider with the written requirements and process to:

- enroll as a waiver provider;
- provide waiver services; and
- submit documentation for payment of services rendered.

Participants or legal representatives selecting Waiver Personal Care Services (WPCS) and/or Respite Care services can hire an unlicensed adult who is not the spouse, or legally responsible adult, parent, step-parent, or foster parent of a minor and is enrolled with the county's Department of Social Services In Home Supportive Services (IHSS) as a Personal Care Service (PCS) provider.

Participants or legal representatives may hire individual licensed providers to provide the following waiver services.

- Case Management
- Community Transition Services
- Private Duty Nursing
- Transitional Case Management
- Medical Equipment Operating Expenses
- Family Training
- Respite Care

The following individual licensed providers are eligible to enroll as wavier providers.

- Registered Nurse
- Licensed Vocational Nurse
- Licensed Clinical Social Worker
- Marriage and Family Therapist
- Licensed Psychologist

Participants or legal representatives can obtain lists of unlicensed providers from their county's IHSS program, licensed providers from CDHS/IHO or they can select an unlicensed or licensed provider who is not enrolled as provider. Upon

selecting a licensed or licensed provider, CDHS/IHO will advise the potential provider of the enrollment process and the roles and responsibilities of becoming a waiver provider.

Prior to rendering care, unlicensed providers must demonstrate their ability to meet the care needs of the participant as described on the participant's plan of treatment (POT). It is the responsibility of the participant or legal representative to determine if the unlicensed provider has the knowledge, skills and abilities to meet the care needs of the participant. Upon request from the participant or legal representative, the unlicensed provider will receive training on providing appropriate service to meet the needs of the beneficiary. This training can come from the primary care physician or medical team, which may include clinical staff from the primary care physician's office or other specialists, and other licensed providers that may be rendering waiver services.

Prior to rendering care, licensed providers that have been selected by the participant or legal representative must submit to CDHS/IHO the required documentation that is described in the Standards of Participation for the individual's provider type. CDHS/IHO will assess the documentation to determine if the licensed provider has the experience to provide the care as described in the participant's POT.

CDHS/IHO will interview the participant or legal representative at each home reassessment visit as to the unlicensed and/or licensed provider's knowledge, skills and abilities to provide the care as describe on the POT. This information will be documented in the CDHS/IHO Case Report. Any identified issues with the delivery of waiver service(s) by the unlicensed or licensed provider will be discussed with the participant or legal representative and an action plan will be developed. CDHS/IHO will interview the participant or legal representative as to the effectiveness of the action plan. In the event issues effect or may effect the health and safety of the participant, CDHS/IHO will complete an Event/Issue Report, report to the primary care physician and to the appropriate law enforcement, child or adult proactive services, as applicable.

CDHS/IHO instructs the participant or legal representative to notify CDHS/IHO if the participant is subject to abuse, neglect and/or exploitation and how to report such incidents to the appropriate authority, such as, law enforcement, child or adult protective services and/or the individual's licensing board.

Prior to authorizing waiver services CDHS/IHO notifies the participant's

primary care physician who oversees the participant's home program that the participant or legal representative has selected an unlicensed and/or licensed provider who works under the direction of the participant or legal representative and is not an employee of an organization or agency.

CDHS/IHO must be in receipt of a current POT describing all the services the participant receives, which includes the provider of services, that is signed by the participant or legal representative, the **primary care** physician overseeing the participant's home program, the licensed provider who prepared the POT, and the unlicensed and/or licensed waiver provider prior to authorizing waiver services.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

X	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
○	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

X	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
☐	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
☐	The participant direction opportunities are available to persons in the following other living arrangements *(specify)*:

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

○	Waiver is designed to support only individuals who want to direct their services.
X	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

CDHS/IHO staff provide information about participant direction opportunities to the participant or legal representative at the time of the initial face-to-face intake assessment. The opportunity is also described in the *HCBS Waiver Informing Notice* and the *Menu of Health Services*.

If the participant or legal representative expresses interest in hiring an unlicensed provider to provider WPCS and/or Respite services, CDHS/IHO provides the participant with a *Waiver Personal Care Information Packet* which describes the roles and responsibilities of the participant, legal representative, the participant's **primary care** physician, CDHS/IHO and the unlicensed provider. The packet includes information on the:

- requirement for two or more personal care providers when a participant is authorized to receive 360 hours or more a month of combined IHSS

PCS and HCBS Personal Care Benefit services;

- waiver services can only be authorized upon CDHS/IHO receipt of a current, complete and signed POT;
- participant or legal representative is responsible for scheduling the unlicensed provider's hours of service;
- participant or legal representative is responsible for signing the unlicensed provider's timesheet validating the hours on the timesheet were provided; and
- participant or legal representative is responsible for notifying CDHS/IHO upon the hiring and dismissal of providers.

If the participant or legal representative select a licensed provider to provide case management, private duty nursing, medical equipment operating expenses family training and/or respite care services. CDHS/IHO provides the participant or legal representative with an *Individual Provider* letter. The letter explains the:

- roles and responsibilities of selecting an individual provider;
- the participant or legal representative are responsible for scheduling the hours of service;
- the provider can only provide the services as described on the **primary care** physician-signed POT; and
- the participant or legal representative is responsibility for notifying HCBS/IHO upon the hiring or dismissal of providers.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

X		The State does not provide for the direction of waiver services by a representative.
○		The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:
	☐	Waiver services may be directed by a legal representative of the participant.
	☐	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Case Management	X	☐
Community Transition Service	X	☐
Private Duty Nursing	X	☐
Waiver Personal Care Services	X	☐
Respite Care	X	☐
Transitional Case Management	X	☐
Medical Equipment Operating Expenses	X	☐
Family Training	X	☐

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

○	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*
	☐ Governmental entities
	☐ Private entities
X	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i*.

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

○	FMS are covered as the waiver service entitled as specified in Appendix C-3.	
○	FMS are provided as an administrative activity. *Provide the following information:*	
	i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:
	ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:
	iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*
		Supports furnished when the participant is the employer of direct support workers:
		☐ Assist participant in verifying support worker citizenship status
		☐ Collect and process timesheets of support workers
		☐ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
		☐ Other *(specify):*
		Supports furnished when the participant exercises budget authority:
		☐ Maintain a separate account for each participant's participant-directed budget
		☐ Track and report participant funds, disbursements and the balance of participant funds
		☐ Process and pay invoices for goods and services approved in the service plan
		☐ Provide participant with periodic reports of expenditures and the status of the participant-directed budget
		☐ Other services and supports *(specify)*:

Additional functions/activities:	
☐	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
☐	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
☐	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
☐	Other *(specify):*

iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

X	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
	Case Management service assists the participant in developing the POT, which is reviewed and signed by the participant's **primary care** physician. A **primary care** physician signed-POT is required prior to authorization or reauthorization of waiver services.

X	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: **Habilitation Services**
X	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

	CDHS/IHO provides information and assistance to the waiver participants or legal representative. The information is provided verbally during the initial face-to-face assessment for waiver enrollment and at each reassessment visit. The information is also provided in writing in the *Informing Notice* and *Menu of Health Services*. Upon enrollment in the waiver, the participant is assigned a CDHS/IHO Case Manager (CM) who is a registered nurse. The CM is required to advises the participant or legal representative of the option of selecting participant direction services and providers at each reassessment visits and at any time upon request from the participant or legal responsive. Evidence of participant being informed of the option is documented in the CDHS/IHO Case Report and copies of the *Informing Notice* and *Menu of Health Services* is filed in the participant's CDHS/IHO case record. At each participant's reassessment visit the CM interviews the participant or legal representative as to the effectiveness of the provider's ability to provider the services as described on the POT. At each annual provider visit the CM assess the licensed provider's documentation of the services provided and the participant's response to the services that are being provided per the POT. Information from the interview on the provider's ability to provide the care is documented in the CDHS/IHO Case Report. It is the responsibility of the participant or legal representative to assess the performance of the provider. The participant or legal representative are advised to inform CDHS/IHO of any issues or problems and to notify the appropriate law enforcement agency, child or adult proactive services, county IHSS office and/or licensing board in the event of abuse, neglect and/or exploitation. Only the participant or legal representative have the ability to hire or dismiss an individual provider.

k. Independent Advocacy *(select one)*.

○	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:

X	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

HCBS IHO Waiver participants can elect to terminate participant direction services at any time. The participant or legal representative are advised to call the participant's assigned CM upon the decision to terminate services. The CM will provide the participant or legal representative with a list of alternate waiver providers in the community to select from. The changing to an alternate waiver provider may affect the type and amount of waiver services the participant can receive. CDHS/IHO will work with the participant or legal representative in identifying services that will meet the participant's needs. Upon the participant's identification of an alternative provider CDHS/IHO will work with the existing provider and new provider in transitioning the authorization of services to ensure there is no break in services. The alternate provider must develop a POT that describes all the care needs of the participants, the providers of the services and the frequency of the services. The POT must be reviewed and signed by the participant or legal representative, the participant's **primary care** physician and the providers of wavier services.

If the participant or legal representative are unable to secure an alternative provider CDHS/IHO will offer to transition the participant to a licensed medical facility until a new provider can be secured.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

CDHS/IHO may elect to terminate authorization of participant directed services for the following reasons:

- Lack of a current **primary care** physician-signed POT describing all the participants care services, provider of the services and the frequency of the services
- Participant or legal representative require the provider to provide services that are not included in the POT or beyond to scope of practice of the licensed provider

- Participant or legal representative are unable to keep providers as demonstrated by frequent voluntary termination of the services by the provider and the participant or legal representative refusal to follow the provider enrollment process as described in the provider information packets

Termination of authorization of services will only occur after all attempts by CDHS/IHO to train and inform the participant or legal representative the roles, responsibilities, and requirements of participant directed services have been exhausted or refusal by the participant or legal representative to receive training on hiring and managing their providers.

CDHS/IHO will provide the participant or legal representative with a Notice of Action informing him/her of CDHS/IHO decision to terminate authorization of participant directed services and his/her appeal rights.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n		
	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

Appendix E-2: Opportunities for Participant-Direction

a. **Participant – Employer Authority** *(Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)*

i. **Participant Employer Status**. Specify the participant's employer status under the waiver. *Check each that applies:*

X	**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. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:*
	The Department of Social Services acts is the common law employer. Unlicensed providers must enroll as a IHSS PCS provider at the county's DSS office. Payment for WPCS is processed through the DSS Case Management Information Payrolling System (CMIPS).
☐	**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.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Check the decision making authorities that participants exercise*:

X	Recruit staff
X	Refer staff to agency for hiring (co-employer)
X	Select staff from worker registry
☐	Hire staff (common law employer)
☐	Verify staff qualifications
☐	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:

☐	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
X	Determine staff duties consistent with the service specifications in Appendix C-3.
☐	Determine staff wages and benefits subject to applicable State limits
X	Schedule staff
X	Orient and instruct-staff in duties
X	Supervise staff
X	Evaluate staff performance
X	Verify time worked by staff and approve time sheets
☐	Discharge staff (common law employer)
X	Discharge staff from providing services (co-employer)
☐	Other *(specify)*:

b. Participant – Budget Authority *(Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply***:**

☐	Reallocate funds among services included in the budget
☐	Determine the amount paid for services within the State's established limits
☐	Substitute service providers
☐	Schedule the provision of services
☐	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
☐	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
☐	Identify service providers and refer for provider enrollment

☐	Authorize payment for waiver goods and services
☐	Review and approve provider invoices for services rendered
☐	Other *(specify):*

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

iv. Participant Exercise of Budget Flexibility. *Select one:*

○	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

○	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative/legally responsible adult) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The procedure for informing Home and Community-Based Services (HCBS) In-Home Operations (IHO) Waiver participants and/or his/her legal representative/legally responsible adult(s) of the opportunity to request a fair hearing to appeal a State decision regarding waiver enrollment or waiver services is provided in two (2) pre-printed California Department of Health Services (CDHS) Notice of Action (NOA) letters. A NOA is sent to the participant or his/her legal representative/legally responsible adult when a request for enrollment in the waiver is denied, or when a HCBS service has not been approved as requested or is reduced, terminated, or denied by CDHS/IHO.

The NOA is required for the denial of an initial request for enrollment in the HCBS IHO Waiver, for a HCBS waiver service, and for the reduction, termination, or denial of previously authorized HCBS waiver services(s). The CDHS/IHO mails the NOA for the reduction or termination of continuous and previously authorized services to the participant and/or his/her legal representative/legally responsible adult(s), the **primary care** physician, and the waiver service provider within 10 calendar days of the effective date of the action.

The NOA advises the participant of CDHS/IHO's decision and the reason(s) to 1) terminate or deny waiver enrollment; 2) reduce or terminate previously

authorized waiver services; or 3) deny new or previously authorized waiver services. The NOA includes instructions advising the participant and/or his/her authorized representative(s) on how to request a State Fair Hearing before an Administrative Law Judge (ALJ). The participant must request a State Fair Hearing within 90 calendar days after the date the NOA was mailed to the participant.

If the request for a State Fair Hearing is submitted to the California Department of Social Services, State Hearing Division prior to the expiration date printed at the top of the NOA or within ten (10) calendar days of the date of the notice, the participant's waiver enrollment and/or previously authorized services will continue without interruption. The participant and/or his/her legal representative/legally responsible adult(s) are responsible for submitting the request for a State Fair Hearing before the action takes place. A copy of the NOA is filed in the participant's case record maintained by the CDHS/IHO nurse case manger.

State Plan and waiver services unaffected by the NOA will continue to be provided as authorized. The participant's Medi-Cal eligibility is not affected by a NOA, unless the NOA was issued because the participant no longer met the waiver requirements or LOC, the participant obtained his/her Medi-Cal eligibility through the waiver's income and resource eligibility requirements, or the participant no longer meets regular Medi-Cal eligibility requirements.

Upon request of a State Fair Hearing, CDHS/IHO staff will contact the participant and/or his/her legal representative/legally responsible adult(s) to provide them with additional information on the State Fair Hearing process, pursuant to the Welfare and Institute Codes 10950 et seq. and the California Code of Regulations, Title 22, Sections 50951 et seq., 51014.1 and 51014.2. CDHS/IHO staff will advise them they will receive the CDHS' written position statement before the scheduled hearing date. If the participant and/or his/her legal representative/legally responsible adult(s) have not identified legal representation, CDHS/IHO will refer the participant and/or his/her legal representative/legally responsible adult to the toll-free 800 telephone number listed on the back of the NOA for information regarding hearing rights and free legal aid and to Protection and Advocacy, Inc. CDHS/IHO will continue to work with the participant and/or his/her legal representative/legally responsible adult(s) to resolve the hearing issues before the fair hearing.

If the CDHS Director's Decision upholds CDHS/IHO's action to reduce, terminate, or deny continued enrollment in the waiver and/or a waiver service(s),

any aid paid pending which the participant had been receiving will stop.

The participant can request a rehearing. Instructions on how to request and the grounds for a rehearing are included with the ALJ's written decision. To request a rehearing, the participant must mail a written request within 30 calendar days after receiving the final decision. The participant must state the date the decision was received and the reason(s) why a rehearing should be granted. A request may be granted if the participant submits evidence that was not reasonably available at the hearing that could impact the original decision.

If the participant is unsatisfied with the outcome of the original hearing or rehearing, they can elect to seek a judicial review by filing a petition in Superior Court within one year of receiving notice of the final decision. The participant may file this petition without asking for a rehearing.

The following are reasons for denying initial requests for IHO Waiver services:

- The enrollment cap for the waiver has been met for the current fiscal year (the individual will be placed on a wait list if they so choose.)
- The participant does not meet this waiver's enrollment criteria, as describe in Appendix B.
- The participant or the legal representative/legally responsible adult(s),have not identified Providers who can provide all the **primary care** physician-ordered services at the time of discharge from the acute hospital and attempts have been made by the HCBS waiver service provider and/or MCOD-IHO to assist in identifying providers without success.
- The beneficiary is not able to establish Medi-Cal eligibility.
- The beneficiary or the authorized representative, to the extent the beneficiary needs support, elects in writing to withdraw the request for service.
- The request for services exceeds 24 hours a day of direct care services.
- The beneficiary becomes deceased.

The following are reasons for reduction or termination of waiver services:

- The cost of the requested service(s) exceeds the cost of the individual's cost limit and the participant and/or the primary caregiver does not agree to a reduction in the requested services in order to maintain program cost neutrality;
- The participant loses Medi-Cal eligibility;
- The participant moves from the geographical area in which the HCBS IHO Waiver services were being authorized to a new area where there are

providers of services, but no provider has agreed to render waiver services to the participant;

- The participant's medical condition resulting in frequent emergency hospitalization is unstable as demonstrated by repeated, unplanned hospitalizations, and the waiver does not provide enough support to ensure the participant's health and safety in the community;
- The participant's condition does not meet the medical eligibility criteria for the evaluated LOC described in the waiver;
- The participant or the legal representative/legally responsible adult(s) refuses to comply with the primary care physician's orders on the Plan of Treatment (POT), and CDHS/IHO determines that such compliance is necessary to assure the health, safety and welfare of the participant;
- The participant or the legal representative/legally responsible adult(s) does not cooperate in attaining or maintaining the POT goals which jeopardizes participant health and welfare;
- The identified support network system or the primary caregiver cannot be identified, is not able, or is no longer willing or available to assume the responsibility to act as a back-up for the participant. The CDHS/IHO NE will work with the participant and responsible persons to develop a POT and identify providers so the participant can continue to reside safely in a home-like setting, when possible;
- The home evaluation, completed by the HCBS provider, documents an environment that does not support the participant's health, safety and welfare, or is otherwise not conducive to the provision of HCBS waiver services;
- The HCBS waiver service provider is unwilling or unable to provide the amount of authorized services as ordered by the participant's POT and/or **primary care** physician's order. If this inability to provide services impacts the health and safety of the participant and, at the request of the participant and/or the legal representative/legally responsible adult(s), the CDHS/IHO shall assist with the authorization process for the participant by assisting and accessing the location of a licensed health care facility, until another HCBS waiver service provider accepts the responsibility for providing services in the home setting;
- Any documented incidence of noncompliance by the participant or legal representative/legally responsible adult(s)(s) with the requirements of this agreement that poses a threat to the health or safety of the participant, and/or any failure to comply with all regulatory requirements;

- The participant and/or his/her legal representative/legally responsible adult(s)(s) and/or circle of support are requesting direct care services that exceed 24 hours per day and do not agree to a reduction of services so as not to duplicate services;
- The participant receives 360 hours per month or greater of combined In-Home Supportive Services (IHSS) Personal Care Services (PCS) and WPCS services, and does not have two (2) or more personal care providers to protect the safety of the participant;
- The participant, legal representative/legally responsible adult(s)(s), ~~treating~~ **primary care** physician, or waiver service provider has not submitted to CDHS/IHO a complete and current **primary care** physician-signed POT within 180 days of the initial evaluation or within 60 days of the end-date of the previous POT; and
- CDHS/IHO has not received a TAR or the WPCS provider information within 180 days of the initial evaluation or within 60 days of the termination date of the last authorized waiver services.

In the event of a denial, reduction or termination of waiver services and/or enrollment, the CDHS/IHO NE will assist the participant in identifying local community resources that may be available.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

○	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
X	**No**. This Appendix does not apply (*do not complete Item b)*

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

○	**Yes.** The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver *(complete the remaining items)*.
X	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The California Department of Health Services (CDHS)/In-Home Operations (IHO) Nurse Evaluator (NE) will document all reported or observed critical events or issues that may affect the health, safety and welfare of waiver participants. Critical events or incidents are those reported or observed of participant abuse (physical/sexual) or neglect, incidents posing an imminent danger to the participant, fraud or exploitation (including misuse of participant's funds and/or property), or a dangerous physical environment. The CDHS/IHO NE provides instruction to the participant, his/her legal representative/legally responsible adult(s) and/or members of his/her circle of support on how to report events or issues that affect or can affect the health, safety and welfare of the waiver participant.

The CDHS/IHO NE will use the Event/Issue Report form to document concerns or problems expressed by the participant, his/her legal representative/legally responsible adult(s)s and/or circle of support to ensure timely investigation and resolution. In the case the event/issue is observed by a waiver provider and reported to the CDHS/IHO NE, the CDHS/IHO NE will document the waiver service provider's report in the participant's case record and complete an Event/Issue Report documenting the incident.

The Event/Issue Report form is designed to document:

- A description of the event or issue (the who, what, when and where);
- Who reported the event or issue;
- The State and local agencies, the **primary care** physician, and law enforcement who were notified and when;
- The plan of action to address/resolve the event or issue (who, what, when); and

- The resolution and date resolved.

A copy of the completed Event/Issue Report form is maintained in the participant's case record and updated to document the resolution of the event/issue.

Incidents of possible abuse, neglect or exploitation require the CDHS/IHO NE to report the incident to the supervising CDHS/IHO NE and to the appropriate local or State agencies. CDHS/IHO will adhere to the Health Insurance Portability and Accountability Act of 1996 to ensure the participant's Personal Health Information is protected. The CDHS/IHO NE is responsible for documenting the referral in the participant's case record, including the agency and the name of the person(s) who received the referral and the person(s) responsible for conducting the investigation. Referrals are made to the following agencies:

- Adult Protective Services (APS);
- Child Protective Services (CPS); and
- Local law enforcement.

The Event/Issue Report form is used to communicate with the CDHS Licensing and Certification (L&C) on events/issues affecting participants that are related to home health agencies (HHA), adult day health care (ADHC) providers, pediatric day health care (PDHC) providers, congregate living health facilities (CLHF), and certified home health aides (CHHA). L&C will determine if the provider is in compliance with the California Health and Safety Code Sections 1736-1736.7 (CHHA), 1575-1575.7 (ADHC), 1760-1761.8 (PDHC) and 1250(i) (CLHF). After consulting with the Supervising CDHS/IHO NE, the CDHS/IHO NE forwards the completed confidential Event/Issue Report to L&C with a request that L&C investigate when there has been:

- Failure by the Medi-Cal provider to report abuse or neglect of a waiver participant. L&C will also notify the appropriate local or State agencies;
- Failure to notify the **primary care** physician of a change in the participant's condition, if the participant is harmed by the failure of this action;
- Failure to inform the participant and/or his/her legal representative/legally responsible adult(s)s of the participant's "Patient Rights",;
- Failure to comply with the participant's "Patient Rights";

- Failure to complete the appropriate documentation and/or notify the participant's **primary care** physician of an incident;
- Failure to provide services or supplies as described on the POT, ordered by the **primary care** physician and agreed to provide;
- Inadequate or inappropriate evaluation of the participant's needs (e.g., weight loss not assessed),;
- Inadequate notification to the participant when services or supplies are changed or terminated; and,
- Failure to act within a professional's scope of practice..

The participant's case record is updated to document the event/issue resolution and closure, and L&C actions and recommendations. During L&C's investigation, the CDHS/IHO NE will continue to work with the waiver providers, the participant's **primary care** physician, the participant and/or his or her legal representative/legally responsible adult(s) and/or circle of support to ensure that the participant receives needed services and can continue to reside safely in the home.

b. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representative/legally responsible adult(s)s, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representative/legally responsible adult(s)s, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The CDHS/IHO NE is responsible for informing and discussing with the participant, his/her legal representative/legally responsible adult(s)s, and/or members of his/her circle of support, how to identify and report issues of abuse, neglect or exploitation that impact the health, safety, and welfare of the participant. The CDHS/IHO NE discusses with the participant the different types of abuse, neglect, or exploitation and how to recognize if any of these occur and whom to contact to report such events/issues.

Each waiver participant, his/her **primary care** physician and all Home and Community-Based Services (HCBS) waiver services providers receive the "HCBS Waiver Informing Notice" that includes a description of the roles and responsibilities of the participant, primary caregivers, **primary care** physician, and the HCBS waiver services provider. It also includes information on how to notify the CDHS/IHO NE if there are any issues or

concerns that may impact the safety, health, and welfare of the participant.

The CDHS/IHO NE evaluates the participant for issues of abuse, neglect, and exploitation during the initial face-to-face visit and at each reevaluation visit. The CDHS/IHO NE is required to provide the participant and/or his/her legal representative/legally responsible adult(s), his/her primary caregiver and members of the participant's circle of support with information on what constitutes abuse (physical, mental and emotional), neglect, and exploitation, and how to report these issues. The CDHS/IHO NE documents these steps in the participant's case report as well as any actions taken.

If an event/issue is reported to, or observed by, the CDHS/IHO NE, the CDHS/IHO NE will document the incident using the Event/Issues Report form and update the participant's case record. Any issues regarding delivery of services which impact the health, safety and welfare of the participant are reported to the **primary care** physician and, when necessary, to the appropriate local protective service agency, law enforcement and/or CDHS L&C.

c. **Responsibility for Review of and Response to Critical Events or Incidents**. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

When an event/issue is observed by or reported to the HCBS waiver provider, the HCBS waiver provider has the responsibility to notify the CDHS/IHO NE, and if applicable, other agencies (CPS, APS, or law enforcement). When an event/issue is identified by, or reported to the CDHS/IHO NE, the CDHS/IHO NE will complete an Event/Issue Report form. The report is designed to document: who the report is from; the type of event or issue; the date and time of the event/issue, if applicable; the location of the incident (participant's home, etc.); details of the event; involved parties; the source of the information; individuals who have first-hand knowledge of the event; whether the **primary care** physician was notified; and the name, address and phone number of the **primary care** physician and any other agencies or individuals that were also notified. The specific nature of an event or issue will determine if notification of others is warranted, e.g., CPS, APS, California Children's Services, Regional Center, law enforcement, and/or CDHS L&C. Any contact made with other agencies or individuals will be kept confidential.

The CDHS/IHO NE will discuss the issues with the CDHS/IHO NE

Supervisor and develop a plan of resolution. All plans developed to resolve identified problems are thoroughly evaluated by the CDHS/IHO NE Supervisor to ensure that they are appropriate, will result in a resolution, which is amenable to the participant and/or his/her legal representative/legally responsible adult(s), and will ensure the participant's health, safety and welfare. All contact made by the CDHS/IHO NE with a HCBS provider of service, the **primary care** physician, the participant and/or the legal representative/legally responsible adult(s) related to the identified event/issue are confidential and clearly summarized and documented in the participant's case record by the CDHS/IHO NE. The CDHS/IHO NE will continue to follow-up with the HCBS provider(s) of service(s), the **primary care** physician, the participant, and, if appropriate, the legal representative/legally responsible adult(s), and other agencies, if appropriate, for resolution. The CDHS/IHO NE will keep the participant and/or his/her legal representative/legally responsible adult(s) informed of the progress of the investigation and will continue to follow-up until the issue is resolved. If the issue is not resolved within 30 days, the CDHS/IHO NE will discuss the issue(s) with the CDHS/IHO NE Supervisor and develop an alternative plan for resolution.

In the event a significant incident occurs, jeopardizing the health, safety and welfare of the participant while under the care of a HCBS waiver provider, the HCBS waiver provider shall submit written documentation to the CDHS/IHO NE for review. The HCBS waiver provider and the CDHS/IHO NE will act immediately on any report of incidents placing the waiver participant in immediate or imminent danger, including contacting local law enforcement when the event/issue is abuse, neglect, and/or exploitation, and/or APS or CPS, as applicable, and as required by law. Within 24 hours of learning of or observing such events, the CDHS/IHO NE will complete an Event/Issue Report. When a determination has been made that other agencies or entities need to be involved in the response to, and resolution of, the event/issue, the CDHS/IHO NE will contact the appropriate agency and provide the necessary information and documentation to assist in the investigation. The CDHS/IHO NE will continue to follow-up with the appropriate agency and keep the CDHS/IHO NE Supervisor and the participant informed of the situation.

Events/issues referred to CDHS L&C are tracked to ensure that CDHS/IHO can adequately respond to the reported findings and plan for resolution of the event/issue. The CDHS/IHO NE will follow up with the participant and/or legal representative/legally responsible adult(s) to make sure the issue has been resolved and there is no longer any risk to the participant's health, safety

and welfare.

d. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The CDHS/IHO Quality Assurance (QA) Unit is responsible for the oversight of event/issue reporting and response to critical incidents. Copies of completed event/issue report forms are maintained electronically for use in quality assurance monitoring. The CDHS/IHO QA Unit tracks the use of the Event/Issue Report form, completeness of the form, documentation of the event/issue, entities contacted, implementation of the plan(s) of action, and resolution.

CDHS/IHO' QA Unit conducts an annual quality management case record review to determine: (1) if the CDHS/IHO staff are completing and submitting to the QA Unit the event/issue report for all events and issues that may or are affecting the participant's health and safety; (2) whether an appropriate action plan was developed and the outcome; and (3) whether systemic program issues exist that require remediation. The findings of the quality management case record review are documented in an annual report prepared by the QA Unit. Based upon the information in the annual report, CDHS/IHO will develop action plans to address deficiencies in reporting and/or identified systemic issues.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when the use of restraints and/or restrictive interventions is permitted during the course of the provision of waiver services regardless of setting. When a state prohibits the use of restraints and/or restrictive interventions during the provision of waiver services, this Appendix does not need to be completed except for Item G-2-c-ii.

a. Applicability. *Select one:*

X		This Appendix is not applicable. The State does not permit or prohibits the use of restraints or restrictive interventions *(complete only Item G-2-c-ii)*
○		This Appendix applies. Check each that applies:
	☐	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. *Complete item G-2-b.*
	☐	Services furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. *Complete item G-2-c.*

b. Safeguards Concerning Use of Restraints or Seclusion

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

c. Safeguards Concerning the Use of Restrictive Interventions

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods

(not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility**. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The CDHS/IHO NE is responsible for monitoring and ensuring the health, safety and welfare of waiver participants. This is accomplished through initial, scheduled, or unscheduled home visits by the CDHS/IHO NE and/or via telephone contact with participants, his/her legal representative/legally responsible adult(s)s, HCBS IHO Waiver providers, and **primary care** physicians. If the HCBS IHO Waiver provider or the CDHS/IHO NE observes or learns that restrictive interventions are being used, an Event/Issue Report form must be completed. The CDHS/IHO NE must determine: 1) whether the use of restraints is ordered by the **primary care** physician; 2) if a plan describing criteria for use and monitoring of restraints is documented in the participant's Plan of Treatment (POT); and 3) if the plan is being followed by the caregivers and/or providers.

If the CDHS/IHO NE determines that the **primary care** physician has not authorized the use of restraints, or the use of the restraints is not in compliance with the POT, the appropriate law enforcement and either child or adult protective services be will contacted to report the event. Unauthorized use of restraints by a HHA, ADHC, PDHC and/or CLHF is referred to CDHS L&C to investigate and report on their findings. The CDHS/IHO NE is responsible for monitoring CDHS L&C's investigation and findings.

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○	**Yes**. This Appendix applies *(complete the remaining items)*.
X	**No**. This Appendix is not applicable *(do not complete the remaining items)*.

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

○	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*
○	Not applicable (*do not complete the remaining items*)

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider

personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

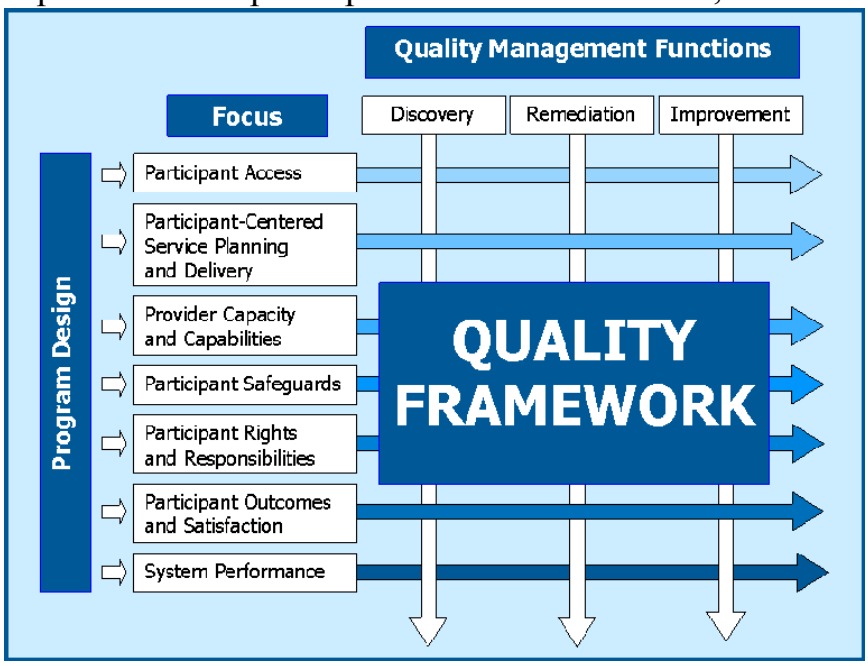
iii. Medication Error Reporting. *Select one of the following:*

○	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to *record:*
	(c) Specify the types of medication errors that providers must *report* to the State:
○	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix H: Quality Management Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.



Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of

this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:
   - Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
   - The entities or individuals responsible for conducting the discovery/monitoring processes;
   - The types of information used to measure performance; and,
   - The frequency with which performance is measured.
2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver**

administrative entities identified in Appendix A, waiver participants, advocates, and service providers.

Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.

3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*
4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*
5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy**.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

California Department of Health Services (CDHS) In-Home Operations' (IHO) Quality Management Strategy is to develop and implement discovery tools and methods to evaluate CDHS/IHO' effectiveness in compliance with the waiver assurances and CDHS/IHO policies and procedures. As a result of discovery activities, CDHS/IHO will develop, implement, and evaluate remediation actions to enhance, correct, and/or improve CDHS/IHO' compliance. The CDHS/IHO Quality Management Unit (QMU) is responsible for developing discovery activities, collecting, and analyzing the data from the discovery activities. The staff of the QMU includes: a research analyst, waiver analysts, an eligibility analyst, an information system analyst, and licensed medical professionals. The CDHS/IHO Section Chief, Managers, Nurse Evaluator (NE) Supervisors, and QMU are responsible for the development, implementation, and evaluation of remediation actions. The QMU utilizes the following tools for discovery:

- Internet-based Case Management Information Systems (CMIS);
- Case Record Review;
- Provider Visit Review;
- Event/Issue database;
- California Medicaid Management Information System (CA-MMIS); and
- California Department of Developmental Services' Case Management Information Payrolling System (CMIPS).

The CMIS is a new database developed and implemented in 2005. During 2006, CDHS/IHO will begin using information from CMIS to establish new quality indicators that will help determine if changes need to be made to the waiver enrollment criteria, services, providers, or any other aspect of waiver administration. CMIS program can provide data on how potential participants are referred to the waiver, how many referrals are received, document the timeliness of the referral, evaluation, and enrollment process, captures data on applicants who are placed on the wait list, and track the reasons active waiver cases are closed. CMIS will also allow CDHS/IHO to document the utilization and cost of WPCS services as well as track Notice of Action (NOA) and capture the number of requests for state hearings along with the outcomes of those hearings.

The QMU and the CDHS/IHO Medical Consultant, who is a licensed physician, are responsible for conducting the annual Case Record Reviews on active HCBS IHO Waiver cases. The selected sample size for the number of case records to be

reviewed is determined by using the Sample Size Calculator located at http://www.surveysystem.com/sscalc.htm. The QMU will randomly select a sample of case records with a 95% level of confidence with a 5% interval for the entire waiver population. The waiver population includes all waiver participants that were open to the waiver anytime during the selected waiver year. Using the identified sample size indicated by the Sample Size Calculator, the QMU will select the cases for review based upon the corresponding percentage of participants at each level of care (LOC) by CDHS/IHO field office location and will ensure that all CDHS/ IHO NE staff are represented in the cases selected for review. The Case Record Review uses a Record Review Tool designed to document the following:

- Evidence of the accuracy of LOC evaluation;
- The participant, and/or his/her legal representative/legally responsible adult(s)(s), and/or circle of support, which includes individuals identified by the participant, and their involvement in the development of the Plan of Treatment (POT);
- The POT appropriately addresses all of the participant's identified needs' and assures participant's health and welfare;
- The participant, and/or his/her legal representative/legally responsible adult(s)(s), and circle of support's knowledge of issues concerning abuse, neglect, and exploitation and how to report them;
- The POT reflects that all the participant's services are planned and implemented in accordance with their unique needs, expressed preferences and decisions, personal goals, abilities, and health status in mind;
- Information and support is available to help the participant, and/or his/her legal representative/legally responsible adult(s)(s) and/or circle of support to make selections among service options and providers;
- The design of the participant's home and community-based program is cost neutral;
- The POT addresses the need for HCBS healthcare and other services; and
- The CDHS/IHO NEs level of compliance with CDHS/IHO' policies and procedures in the completion and maintenance of the waiver participant's case report.

The annual Case Record Review also uses the Record Review Tool to document compliance with the assurances provided in the HCBS IHO Waiver and CDHS/IHO' policies and procedures for annual provider visits conducted by the CDHS/IHO NEs. The Provider Visit Review is conducted on a sample of the

waiver providers who have provided services during the designated waiver year. The Provider Visit Overdue report is used to track annual provider visits that are 30 days overdue. The Provider Visit Review discovers if the CDHS/IHO staff conducts timely provider visits, ensures providers meet the waiver licensing and certification requirements, provides written feedback to the provider following a provider visit, notifies appropriate agencies of provider issues that effect the health and safety of the waiver participant, and documents that the provider has received HCBS waiver training.

CDHS/IHO Event/Issue database captures the type and number of events and issues that affect or can affect the health and safety of the waiver participant, the timeliness of the reporting, and the participant's and/or his/her legal representative/legally responsible adult(s)(s), and circle of support's satisfaction with the outcome of the action plan for the reported issue or event. Reports are developed bi-annually and annually and evaluated for possible remediation actions.

The CA-MMIS and CMIPS databases are used to run utilization and expenditure reports to document that CDHS/IHO is meeting the waiver's cost assurances. CDHS/IHO annually submits a list of participants who were active on the waiver for the reporting year to the CDHS claims data-reporting contractor, Thomson/MedStat. Thomson/MedStat is responsible for running utilization and expenditure reports for waiver participants and peer groups and providing this data to the CDHS
Medi-Cal Policy Division (MCPD), Waiver Analysis Section (WAS), and CDHS/IHO for analysis.

Using these tools, CDHS/IHO will be able to collect and analyze data for trends and patterns of populations served and make changes to policy, procedures, and resources based on that analysis. This information will be used to plan for future outreach activities. CDHS/IHO can then develop any needed remedial actions deemed necessary to provide the best service to the HCBS waiver population while assuring compliance with waiver assurances as well as CDHS/IHO polices and procedures.

H.1.a: Level of Care (LOC) Determination

LOC determinations are conducted for all applicants and enrolled participants utilizing the tools, procedures, and processes described in Appendix B-6. The QMU utilizes the CMIS and the Case Record Review to monitor the timeliness and accuracy of the LOC initial and re-evaluations determinations. The CMIS captures the data documenting:

- CDHS/IHO *received* the HCBS Waiver Application;
- CDHS/IHO *reviewed* the HCBS Waiver Application;
- The applicant received an evaluation prior to enrollment in the HCBS IHO Waiver;
- The applicant was enrolled in the HCBS IHO Waiver; and
- When the next re-evaluation visit is due, based upon the level of case management.

The annual Quality Assurance Case Record Review conducted by the QMU staff and the CDHS/IHO Medical Consultant evaluates the accuracy of the LOC determination based on the information documented in the participant's case report.

IN 2007, the QMU will use CMIS to conduct discovery activities on 100% of the case records to determine if the evaluation visit was conducted as described in Appendix B. The CDHS/IHO NE is responsible for the evaluation visit and waiver eligibility determination. The CDHS/IHO staff consists of registered nurses (RN), identified as CDHS/IHO NEs and their Supervisor who is also a RN. The CDHS/IHO NE must submit evidence of the evaluation visit and documentation of the LOC determination to the CDHS/IHO Supervisor for the applicant to be enrolled in the HCBS IHO Waiver. Only the CDHS/IHO Supervisor and the QMU has permissions to enter the enrollment information in CMIS. The CMIS has an edit that will not allow the participant to be transitioned to the waiver unless the date of the evaluation visit has been entered. Transition is documented by entering the date the participant was approved eligible for the CMS approved HCBS IHO Waiver.

The QMU will run monthly reports identifying the home visit date, enrollment date and LOC determinations for all cases opened for that month. A quarterly and annual report and analyses will be provided to the CDHS/IHO Section Chief, Managers and Supervisors, here after referred to, as CDHS/IHO Management Team. Based upon the report, remediation actions will be developed by the CDHS/IHO Management Team and QMU. The QMU and Supervisors will provide training to the CDHS/IHO NEs on the remediation activities. The QMU will conduct monthly follow-up discovery activities to determine the effectiveness of the remediation actions and ensure understandability and user-friendly assistance is available.

Re-evaluations of LOC determinations are conducted as described in Appendix B. The CDHS/IHO NE is responsible for conducting timely LOC re-evaluations. QMU uses the CMIS to discover the timeliness of the reevaluation LOC

determinations using the Home Visit Over Due Report. This report calculates the date of the next LOC re-evaluation based upon the date of the last LOC evaluation and the participant's level of case management. The QMU runs a monthly report that identifies participants who have not had their LOC re-evaluation completed within 30 days of the calculated date. These reports are provided to the CDHS/IHO Management Team for the development of remediation activities to ensure regular, systematic, and objective methods are used to monitor a participant's well being and health status. The QMU provides a quarterly and annual report and analysis of the timeliness of the re-evaluation visits to the CDHS/IHO Management Team. Remediation actions will be developed based upon the level of compliance. The QMU and Supervisors will provide training to CDHS/IHO NE. The QMU will conduct monthly follow-up discovery activities to determine the effectiveness of the remediation actions.

The QMU and CDHS/IHO Medical Consultant conduct the annual Case Record Review on a sample of participants who were enrolled in the waiver during the reporting waiver year. The QMU uses the Sample Size Calculator as previously described to determine the number cases for review. The cases selected for review will reflect the percentage of cases for each LOC in the waiver, percentage of cases per CDHS/IHO field office and ensure cases from all CDHS/IHO NEs are represented. The CDHS/IHO NE use a case report form to document their observations, actions, and information obtained during the participant's initial and re-evaluation visit. The CDHS/IHO NE document the participant's medical care needs and the justification of the LOC determination in the case report and use the criteria and regulations cited in the waiver in making the LOC determinations. It is CDHS/IHO' policy that the Supervisor reviews all case reports. Once the Supervisor has determined the case report is complete and is in agreement with the LOC determination, the Supervisor signs and dates the case report. If the Supervisor and CDHS/IHO NE are not in agreement with the LOC determination, the case report is reviewed by the CDHS/IHO Medical Consultant. The CDHS/IHO Medical Consultant's LOC determination is final and documented in the case report.

The annual Case Record Review is used to discover the CDHS/IHO NE level of compliance with completing the case report and if the LOC determinations are in compliance with the HCBS IHO Waiver facility alternatives. Within 90 days of the review, the QMU will present an analysis of the findings to the CDHS/IHO Management Team. Based upon the findings and level of compliance, remediation actions will be developed and implemented by the CDHS/IHO Managers, CDHS/IHO Medical Consultant, Supervisors, and QMU within 90 days to develop procedures to ensure participant safeguards. Effectiveness of the

remediation actions will be monitored by the CDHS/IHO Medical Consultant and Supervisors and re-evaluated at the next year's annual Case Record Review.

H.1.b: Service Plan

During the annual Case Record Review, the QMU uses the Record Review Tool to discover if the participant has a service plan, hereafter referred to as the POT, which is current in accordance with the standards described in Appendix B-7.

At the annual Case Record Review, the case report is evaluated for documentation by the CDHS/IHO NE to show that:

- The participant and/or his/her legal representative/legally responsible adult(s)(s) and/or their circle of support exercise a high degree of involvement in the identification, development, and management of services and supports that meets the participant's needs;
- The services are delivered as described in the POT;
- The POT is modified to meet changing circumstances;
- The participant and/or his/her legal representative/legally responsible adult(s)(s), and/or circle of support was informed of all the services and provider types available, and,
- If the POT did not reflect the participant's needs or was not observed to be successful, what corrective actions were taken and the result of the actions.

The annual Case Record Review looks for evidence in the case record for:

- Freedom of Choice document signed by the participant and/or his/her legal representative/legally responsible adult(s)(s) stating they were informed of the choice of receiving care in their home and community in lieu of facility care;
- Copies of Informing Notices sent to the participant and/or his/her legal representative/legally responsible adult(s)(s), current provider(s) and the current **primary care** physician overseeing the home program;
- Current Menu of Health Services (MOHS), which lists all waiver services and provider types and identifies the services and providers the participant or legal representative/legally responsible adult(s) has selected; and
- All the services identified on the MOHS are described on the participant's POT.
- Within 90 days of the review, the QMU will present an analysis of the findings to the CDHS/IHO Management Team. The analysis will include an evaluation of the waiver's impact to the participant's health and welfare and identify any risks to the participant and how those risks will be

managed. Based upon these findings and level of compliance, remediation actions will be developed and implemented by the CDHS/IHO Managers, Supervisors, and QMU within 90 days. Effectiveness of the remediation actions are measured during the following year's annual Case Record Review.

H.1.c: Qualified Providers

The annual Case Record Review, conducted by the QMU, uses the Record Review Tool to discover evidence in the case record that the waiver providers were licensed and/or certified at the start of service, continue to have a current and active license and/or certification, and that they initially and continue to meet the waiver provider requirements as described in Appendix C-3. The evidence includes copies of professional licenses, State and Medi-Cal certification, copies of current basic life support certification, and documentation of education and work experience as described in the HCBS IHO Waiver SOPs. The Record Review Tool is designed to determine if the provider received an annual visit by CDHS/IHO staff, if the participant's chart maintained by the provider is current, if the provider is rendering the care as described on the participant's POT, and if the CM has evaluated the provider for any training needs and actions rendered as a result of the evaluation.

The Record Review Tool is used to document evidence the WPCS provider, who is a non-licensed/non-certified individual who initially and continues to meet the CDHS/IHO WPCS provider requirements. Evidence includes documentation for each provider of enrollment in the county's In-Home Supportive Services (IHSS) Personal Care Services program, and a copy of each provider's Driver's License, Social Security Card, and signature.

During the annual Case Record Review, the QMU runs a report from CMIS identifying all the participant's HCBS Waiver providers to ensure providers are available and have the skills, competencies, and qualifications to support the participant effectively. This report is used to discover if the CDHS/IHO NE have obtained the required documentation for all of the participant's HCBS waiver providers.

Within 90 days of the review, the QMU will present an analysis of the findings to the CDHS/IHO Management Team. Based upon the findings and level of compliance, remediation actions will be developed and implemented by the CDHS/IHO Managers, Supervisors, and QMU within 90 days. Effectiveness of the remediation actions will be re-evaluated at the next year's annual Case Record Review.

In 2008, CDHS/IHO will begin development of a Provider Satisfaction Survey. The survey is a mechanism to secure feedback from providers, to evaluate the provider's satisfaction of being a HCBS IHO Waiver provider, the effectiveness of the HCBS IHO Waiver services in supporting the participant's choice to receive care in his/her home and community in lieu of care in a facility, and solicit suggestions for improving the HCBS IHO Waiver and/or processes. The goal will be to conduct a survey in 2009.

The timeline for this action is as follows:

- 1/1/08 - 4/30/08 - Conduct research on the Provider Satisfaction Surveys and select a model.
- 5/1/08 - 7/31/08 - Develop a survey, instructions and evaluation criteria. Have the appropriate Branch managers review and approve the survey and instructions.
- 8/1/08 - 10/30/08 - Ask a small sample number of providers to review the survey and provide feedback.
- 11/1/08 - 12/31/08 - Make changes to the survey and instructions based upon the provider's feedback.
- 2/1/09 - 3/15/09 - Issue and collect the survey by mail with possible follow-up by CDHS/IHO NE staff to help ensure a reasonable percentage of input by providers.
- 3/16/09 - 4/30/09 - Analyze and evaluate the results of the survey by provider type and present recommendations to CDHS/IHO Management Team. Provide results and recommendations to the providers and solicit their input.
- 5/1/09 – 7/31/09 - Develop and implement a remediation plan based upon all input. Determine frequency of future Provider Satisfaction Surveys.

H.1.d: Health and Safety

CDHS/IHO' staff is responsible for completion of an Event/Issue Report when they either discover or receive information of an event or issue that affects or can affect the health and safety of a participant. The Event/Issue Reports are sent to the QMU. The following information is entered into the Event/Issue Database:

- Date the event/issue was discovered or reported;
- Date the event/issue occurred;
- Type of event/issues (i.e. staffing, medication, equipment, abuse, neglect, exploitation);
- Date the event/issue was resolved; and

- Participant, legal representative/legally responsible adult(s), and/or circle of support 's satisfaction with the outcome.

The data is analyzed and monitored for ongoing concerns of affected participants, documentation of the interventions, timeliness of the actions, and participant, legal representative/legally responsible adult(s), and/or circle of support's satisfaction. The results of the analysis are presented semi-annually, annually or as needed to the CDHS/IHO Management Team. The CDHS/IHO Management Team will determine what changes in training, education, policies and/or procedures need to be made to protect the health and safety of the waiver's participants. Evidence of the effectiveness of the changes will be discovered through the annual Case Record Review.

The annual Case Record Review conducted by the QMU uses the Record Review Tool to document the evidence in the case record and the Provider Visit Report of the CDHS/IHO NEs evaluation of the participant's health and safety. The case record and Provider Visit Report prompt the CDHS/IHO NE to interview the participant, legal representative/legally responsible adult(s), and/or circle of support about any occurrence of unscheduled hospitalizations, emergency room visits, issues with medications, or any situation that could endanger the participant and document the outcome of these events. The annual Case Record Review looks for evidence that the CDHS/IHO NE have documented their observations of any issues concerning the participant's health care needs such as the need for medications to be managed efficiently and appropriately and notes that safeguards are in place to protect the participant from life endangering situations or conditions of abuse, neglect and/or exploitation. The annual report identifies risk factors and monitors the completion and submission to the QMU of an Event/Issue Report when issues concerning health and safety are identified in the case record or Provider Visit Report so modifications can be offered to promote participant independence and safety.

Within 90 days of the review, the QMU will present an analysis of the findings from the Case Record Review to the CDHS/IHO Management Team. Based upon the findings and level of compliance, remediation actions will be developed and implemented by the CDHS/IHO Managers, Supervisors, and QMU within 90 days. Effectiveness of the remediation actions will be re-evaluated at the next annual Case Record Review to assess health risk and safety safeguards.

In 2007, CDHS/IHO will begin development of a Participant Satisfaction Survey. The goal is to improve access to services and reduce unmet needs while allowing more person centered participation. The survey will allow the

participant and/or legal representative/legally responsible adult(s) to provide feedback to CDHS/IHO anonymously on his/her satisfaction with the services and providers available through the waiver, identify issues that effect their health and safety, inform CDHS/IHO of his/her satisfaction or dissatisfaction with the CDHS/IHO staff, and solicit suggestions for improving the waiver and/or processes. The goal will be to conduct a survey in 2008.

The timeline for this action is as follows:

- 1/1/07 - 4/30/07 – Conduct research on the Participant Satisfaction Surveys and select a model.
- 5/1/07 - 7/31/07 – Develop a survey, instructions and evaluation criteria. Test the survey readability and have it reviewed and approved by the appropriate CDHS/IHO Management Team.
- 8/1/07 - 10/30/07 – Ask a small sample number of participants and legal representative/legally responsible adult(s)s to review the survey and provide feedback.
- 11/1/07 – 12/31/07 - Make changes to the survey and instructions based upon the participants and legal representative/legally responsible adult(s)s' feedback. Develop a policy and procedures to ensure anonymity of participant.
- 2/1/08 – 3/15/08 – Conduct survey and compile responses.
- 3/16/08 – 4/30/08 – Analyze and evaluate the results of the survey regarding the level of participant satisfaction in how the waiver is administered. Present recommendations to CDHS/IHO Management Team. Provide results and recommendations to the participants and solicit their input.
- 5/1/08 – Develop and implement a remediation plan based upon all input. Determine frequency of future participant surveys.

H.1.e: Administrative Authority

CDHS/IHO has sole responsibly for the administration and oversight of who is eligible for the HCBS IHO Waiver, the effectiveness of the participant's POT, the authorization of waiver services, the enrollment of waiver providers, and the monitoring of the participant's health and safety. The effectiveness of administration and oversight activities is discovered through the quality management strategy previously described in this Appendix.

The annual Case Record Review looks for evidence of issuance of a NOA to the participant or legal representative/legally responsible adult(s) when the participant has lost Medi-Cal eligibility, CDHS/IHO has determined the

participant no longer meets the waiver's LOC, there is a change in the participant's LOC resulting in a reduction in waiver services, or the participant does not meet the enrollment requirements as described in this waiver. The NOA provides the participant and legal representative/legally responsible adult(s) with information as to their right to appeal CDHS/IHO' decision.

CDHS/IHO has developed a database that tracks State Fair Hearing requests, the basis of the hearing, and the outcome. The QMU will annually perform an analysis of the data. The analysis will look for trends and outcomes of the hearings that may indicate a need for changes within program policy and procedures. The information will be presented to the CDHS/IHO Management Team. Based upon the need, remediation actions will be developed and implemented by the QMU and Supervisors. Effectiveness of the remediation actions will be re-evaluated at the next Annual Review.

H.1.f: Financial Accountability

The QMU currently conducts ad hoc discovery activities based upon a provider's complaint of non-payment and the suspicion of fraud. The QMU will access either the Surveillance or Utilization Review Subsystem (SURS) or the CMIPS to obtain evidence that a claim was submitted by an HCBS IHO Waiver provider for prior authorization of HCBS IHO Waiver services and was reimbursed at the established rate for the service. The evidence is submitted to the CDHS/IHO Management Team to determine what, if any, further action maybe required. For issues concerning fraud, the QMU will notify the CDHS' Audit and Investigations (A&I) Branch. For issues concerning non-payment for all but waiver personal care services, the QMU, CDHS/IHO NE, Supervisors or Managers will assist the provider in resolving the issues concerning the authorization of services. For issues beyond CDHS/IHO' ability to remedy, the provider will be referred to the Electronic Data System (EDS) Help Desk, and/or CDHS' Med-Cal Payment Systems Division. For non-payment of CDHS/IHO authorized WPCS services, the provider will be referred to the Department of Social Services' IHSS program.

In 2007, CDHS/IHO will begin development of a Claims Quality Management strategy for reviewing HCBS IHO Waiver claims. The quality management strategy will include the following elements:

- Determining the sample size of claims to be reviewed;
- Establish processes for accessing the claims data in SURS and CMIPS;
- Determine if the provider submitting the claim is a qualified HCBS IHO Waiver provider.

- Determine if the reimbursement rate matches the established rate for the service, as noted in the Medi-Cal Provider Manual or CMIPS; and
- Determine if the services were prior authorized in:
  - CA-MMIS,
  - Service Utilization Review Guidance and Evaluation (SURGE), or
  - CMIPS

The QMU will conduct the review annually and provide the CDHS/IHO Management Team with the results within 90 days of the completion of the review. Based upon the results and the level of compliance, the CDHS/IHO Managers and Supervisors will develop and implement remediation activities within 90 days. Effectiveness of the remediation actions will be measured at the next year's annual review.

The timeline for this action is as follows:

- 1/1/07-3/31/07 – Conduct research on other claims discovery processes.
- 4/1/07-6/30/07 – Develop a Claims Review Tool. Conduct a test of the review tool to determine if the tool captures the information needed to determine if the claims are paid accurately and to an approved HCBS Waiver provider.
- 7/1/07-9/30/07 – Make changes to the Claims Review Tool based upon the test.
- Determine the average number of HCBS IHO Waiver claims processed over 2 years and determine a sample size of claims to be reviewed.
- 10/1/07-10/30/07 - Conduct a review on the representative sample of claims.
- 11/1/07-12/15/07 – Complete an analysis of the review and present recommendations to the CDHS/IHO Management Team.
- 1/2/08 – 3/1/08 – Develop and implement remediation actions as needed based upon the results of the review.
- 9/2008 – Implement the annual Claims Review.

H2: Roles and Responsibilities

The QMU is responsible for the measurement of performance, providing analysis when performance falls below the established Levels of Compliance, as described below, and the presentation of recommendations for remediation and improvement to CDHS/IHO' Management Team. In evaluating performance that falls below the established standards, the QMU will determine the cause of the problem or lack of documentation through interviews with the CDHS/IHO

NE who are responsible for evaluating the participant's LOC, overseeing the POT to ensure it meets the participant's medical care needs, reporting issues that affect the health and safety of the participants, and ensuring the waiver providers meet the HCBS IHO Waiver's requirement. The Supervisors are also interviewed, as they are responsible for approving the LOC determinations and evaluating the documentation on the Case Report and Provider Visit Reports for completeness. The results of the interviews will be provided to the CDHS/IHO Management Team for the development of remedial actions. Based upon the need, remediation actions will be developed and implemented by the QMU and Management Team.

The QMU Nurse Consultant conducts weekly meetings to review State Fair Hearings requests that have been filed. The purpose of the meeting is to discuss the cases to ensure all efforts have been made to resolve the issue prior to going to the hearing, to ensure the participant and/or legal representative/legally responsible adult(s) are aware of the fair hearing process and their rights, and review any decisions rendered by the Administrative Law Judge (ALJ) at previous hearings. Attendees include the QMU Nurse Consultant, the CDHS/IHO Medical Consultant, Nursing Supervisors, and the CDHS/IHO NE who will be representing the CDHS at the State Fair Hearing. Lessons learned are shared with staff at the weekly CDHS/IHO Managers and Supervisors meeting and the weekly CDHS/IHO NE meetings. Information from these meetings can lead to process and procedure changes and/or updates to CDHS/IHO policies.

The Managers and Supervisors are responsible for conducting CDHS/IHO NE staff meetings. These meetings occur weekly or bi-monthly depending on workload. The purpose of these meeting is to share information and provide training to the CDHS/IHO NEs. Some of the topics include: new or updated policies and procedures, a discussion of issues that affect the health and safety of waiver participants, presentation of case studies, new CMS and CDHS policies, legislation that can affect the waiver or our participants, and results of QMU activities.

CDHS/IHO conducts annual statewide meetings, as the budget permits, to provide training and updates to all CDHS/IHO staff. Based on areas of need identified by QMU reviews and requests by CDHS/IHO staff, CDHS/IHO locates speakers, identified by CDHS as leaders in their field of expertise, to provide training during these meetings. These training sessions could include such varied subjects as dealing with provider billing issues, elder and dependent abuse in the home setting, or communication issues. Evaluations are collected to determine if the training goals and objectives have been met. The meeting's

minutes will also be reviewed annually by the QMU and a summary of identified issues, remedial actions and follow-up activities will be described in the annual CMS 373 Q report.

The QMU works with Thomson/MedStat, CDHS contractor for cost reports. The QMU provides Thomson/MedStat with the participant's identification number and service identifiers for cost reports for HCBS and State Plan services. Thomson/MedStat will also run cost reports on Medi-Cal beneficiaries who are receiving long term care in an HCBS IHO Waiver's facility alternative. The results of these reports are analyzed by the QMU for trends and patterns across populations and reported to CDHS/IHO Section Chief, Managers, Supervisors and the Medi-Cal Policy Division, Waiver Analysis Section. Evidence of remedial actions will be described in the annual CMS 373 Q report.

H3: Process to Establish Priorities and Develop Strategies for Remediation and Improvement

The CDHS/IHO Management Team is responsible for establishing priorities, remediation, and improvement actions. CDHS/IHO has established the following Levels of Compliance that are used to determine when remediation and improvement actions will occur. These levels of compliance are applied to the reports and reviews described in H1.

Levels of Compliance	
80-100%	Substantial compliance with HCBS IHO Waiver assurances and/or CDHS/IHO Policy & Procedures. No significant remediation actions required.
70-80%	Compliant with HCBS IHO Waiver assurances and/or CDHS/IHO Policy & Procedures, but raises concerns, additional investigation is needed. Remediation action and follow-up focus review as needed.
60-70%	Marginally compliant with HCBS IHO Waiver assurances and/or CDHS/IHO Policy & Procedures, remediation action and follow-up focus review required.
Less than 60%	Non-compliant with HCBS IHO Waiver assurance and/or CDHS/IHO Policy & Procedures, remediation action and follow-up focus review is required.

Regardless of the level of compliance, program issues that affect the immediate health and safety of the participants will receive priority. The issue will be brought to the attention of the Management Team and a remediation plan will be developed and implemented. The remediation plan may include contacting other agencies and State Departments for assistance, changes to CDHS/IHO' policies and procedures and/or requesting assistance from the CMS.

The Level of Compliance score is used to determine the priority in the development and implantation of remediation activities. Level of Compliance scores of less than 60% will require immediate action. A remediation plan will be developed and implemented within 90 days. A follow-up focus review will be conducted 90 and 180 days after implantation of the remediation plan to determine the effectiveness of the plan. Results of the review will be presented to the Management Team for future planning.

Compliance scores of 60-70% will have the next priority and will also require a remediation plan and follow-up focus review. Areas with a compliance review of 70-80% will be further investigated and the CDHS/IHO Management Team will determine if there is a need for a remediation plan. When CDHS/IHO is unable to address all areas of concern, CDHS/IHO will give priority to areas that directly affect the waiver participant. Follow-up focus review will only be conducted on participant related issues. Effectiveness of remedial actions related

H4: Compilation and Communication of Quality Management Strategy

CDHS/IHO' quality management reports are designed as Administrative Management Reports. The following identify the major reports, the topic, frequency, and the recipient(s) of the report.

Name of Report	Topic	Frequency	Recipient(s) of Report
Home Visit Overdue	List of participants whose re-evaluation visit is over due by 30 days or more	Monthly, Quarterly Annually	Supervisors, CDHS/IHO Management
Provider Visit Overdue	Annual Provider visit is overdue by 30 days or more	Monthly, Quarterly Annually	Supervisors, CDHS/IHO Management
Event/Issue Report	By issue, amount of time to resolve, and participant satisfaction	Bi-annual Annually	CDHS/IHO Management
State Fair Hearing Report	By issue and outcomes	Annually	CDHS/IHO Management
Outreach Activities	List of outreach activities, who attended, and average evaluation scores.	Annually	CDHS/IHO Management

In 2008, CDHS/IHO will evaluate the ability to post the results and remediation actions from the Annual Case Record and Provider Visits Reviews on the CDHS website. In 2009, CDHS/IHO will have the ability to post the results and remediation actions from the Participant and Provider Surveys on the website.

H5: Periodic Evaluation and Revision of Quality Management Strategy

The QMU and participants of the Case Record and Provider Visit Review conduct a post-review evaluation of the review process and evaluation tools. Based upon the evaluation, the Case Record, Provider Visit Review Tools and instructions may be revised to remove items that have a history of significant compliance and add new items that have been identified as a potential issue or problem, and modify policies and procedures for how a specific issue is reviewed. CDHS/IHO will conduct a post-review of the implementation of the Provider Satisfaction Survey in the third quarter of 2009, the Participant Satisfaction Survey in the fourth quarter of 2008 and the Claims Quality Management Strategy in the first quarter of 2008. Changes to any of the above processes will be described in the annual CMS 373 Q report.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Home and Community-Based Services (HCBS) In-Home Operations (IHO)Waiver providers are not subject to the requirement of the Single Audit Act (31 U.S.C. 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104-146). California Department of Health Services (CDHS)/IHO does not grant federal or state awards to participating waiver providers.

Payments for most, but not all, HCBS IHO Waiver and State Plan services are made through the approved California Medi-Cal Management Information System (CA-MMIS). The California Department of Health Services (CDHS) Payment Systems Division (PSD) administers the Medi-Cal claiming system and manages the State's third party fiscal intermediary contract with Electronic Data Systems (EDS).

All claims processed through EDS are subject to random post adjudication, pre-payment verification for detection of errors, irregularities, and potential for waste, fraud, or abuse. Specific criteria for appropriate claims processing has been established and measurements against these criteria occur weekly before the release of payments.

The CDHS Audits and Investigations (A&I) Division is responsible for ensuring the fiscal integrity and medical necessity of Medi-Cal program services, including the HCBS IHO Waiver program.

All claims submitted by waiver and State Plan providers are subject to random review regardless of provider type, specialty, or service rendered. A&I verifies that claims selected have sufficient documentation to approve the claim for payment. Providers are notified if a claim requires additional documentation before approval for payment. Failure to comply with the request for additional

documentation may result in suspension from the Medi-Cal program, pursuant to Welfare and Institutions Code (W & I Code), Section 14124.2.

The A&I Division has three branches that conduct reviews using various methodologies to ensure program integrity and the validity of claims for reimbursement.

The A&I Medical Review Branch (MRB) performs essential medical reviews of non-institutional providers. Providers may also be subject to a more comprehensive review on a weekly basis known as a pre-checkwrite review. This review is based on a set of criteria, such as irregular billing patterns, designed to identify potential fraud or abuse. Providers selected for this more comprehensive review will receive an on-site visit by A&I staff. Many of these reviews result in program removal, monetary penalties, or less intrusive sanctions and utilization controls.

MRB also conducts Medi-Cal provider anti-fraud activities that include performing field reviews on new Medi-Cal providers and providers undergoing re-enrollment. MRB is charged with bringing closure to sanctioned providers through audits designed to quantify the abuse, settlement agreement, or permissive suspensions (exclusions) from the Medi-Cal program. Failure to comply with any request by A&I staff for documentation may result in administrative sanctions, including suspension from the Medi-Cal program, pursuant to W & I Code, Section 14124.2.

MRB staff work closely with EDS in data mining and extracting processes as well as the performance of the annual Medi-Cal Payment Error Study.

The A&I Financial Audits Branch performs cost settlement and rate setting audits of institutional providers, i.e. hospitals, nursing facilities, and certain clinics.

The A&I Investigations Branch (IB) conducts investigations of suspected Medi-Cal beneficiary fraud as well as preliminary investigations of provider fraud. IB is also responsible for coordinating provider fraud referrals to the State Department of Justice (SDOJ) and Federal Bureau of Investigation. Suspected fraud or abuse identified through any audit or investigation process is referred to the SDOJ via the IB.

IB and MRB coordinate the placing of administrative sanctions on providers with substantiated evidence of fraud. IB serves as CDHS' principal liaison with outside law enforcement and prosecutorial entities on Medi-Cal fraud.

APPENDIX I-2: Rates, Billing and Claims

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Medi-Cal Policy Division, Rate Development Branch (RDB) establishes the provider payment schedule for Medi-Cal services, conducts rate studies, develops and implements systems to track and constrain the growth of Medi-Cal rates, and responds to rate-related inquiries from providers, associations, and other interested parties. The RDB formulates reimbursement methodologies for fee-for-service outpatient services, and conducts annual rate studies for long-term care providers, which include nursing facilities and home health agencies.

Methodologies for establishing reimbursement rates for Medi-Cal services are described in state statute. Factors considered when establishing or revising provider rates include:

1. For non-physician services, RDB surveys the federal Medicare Part B program to assure that the Medi-Cal rates of reimbursement do not exceed the lowest maximum allowance for the same Medi-Cal State Plan service;
2. Review of standards of care prescribed under state statutes and regulations and identification of service providers;
3. Identification of cost factors;
4. Identification of at least seven states offering a similar type of service, and determining the average rate of reimbursement; and
5. Market survey and identification of rates of reimbursement by governmental and non-governmental third-party payers for the same or similar services.

Changes in the amount the State reimburses for Medi-Cal State Plan and waiver services rates are authorized by the State's Legislature, and approved and implemented by the Governor.

CDHS/IHO uses four methods to establish rates for HCBS IHO Waiver

services, which are based on provider type and the service provided:

- The adoption of published Medi-Cal State Plan or other State Department service rates for similar services;
- Hourly rates established locally by county governments/authorities;
- Annual rate studies; and
- By report for prior authorized services, with minimum and maximum levels of payment described in the service description of Appendix C-2, General Services Specifications.

(Continued on next page)

The table below describes the rate methodology used to establish payment rates for HCBS IHO Waiver services.

Rate Methodology	HCBS Service
Adoption of published service rates for similar State Plan services	▪ Case Management ▪ Family Training ▪ Habilitative Services ▪ Private Duty Nursing, HCBS Provider ▪ Respite
Hourly rates established locally by county government/authorities	▪ Waiver Personal Care Services (WPCS)
Annual rate studies	▪ Respite, inpatient nursing facility ▪ Private Duty Nursing - Home Health Agency ▪ Private Duty Nursing - HCBS Nursing Facility
By report for prior authorized services	▪ Environmental Accessibility Adaptations ▪ Personal Emergency Response (PERS) (activation and monthly service charge) ▪ Medical Equipment Operating Expense

Rates paid for HCBS IHO Waiver services are published in the Medi-Cal Provider Manual and notices of updates are sent to Medi-Cal providers by U.S. mail or by e-mail notices.

CDHS/IHO provides information regarding the payment rates for waiver services to the waiver participants through the use of the Menu of Health Services (MOHS). The MOHS lists available waiver services, eligible providers, and the cost of services, by provider type. Each waiver participant is provided a copy of the MOHS at the initial visit and at each reevaluation visit.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims

payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

CDHS/IHO is responsible for prior authorization of all HCBS IHO Waiver services and verifies that the requested services are in accordance with the participant's Plan of Treatment (POT). HCBS IHO Waiver service providers are responsible for submitting a Treatment Authorization Request (TAR) to CDHS/IHO for prior authorization of all HCBS IHO Waiver services except the WPCS benefit. The CDHS/IHO Nurse Evaluator (NE) reviews the TAR for medical necessity and to ensure services are authorized in accordance with the participant's POT. Claims for services are paid after the service is rendered.

CDHS PSD has overall responsibility for ensuring payment of Medi-Cal claims for authorized services. PSD oversees the contract with EDS, the state's Medi-Cal fiscal intermediary responsible for managing the Centers for Medicare & Medicaid Services (CMS) approved CA-MMIS.

HCBS IHO Waiver providers submit claims to EDS for services rendered using either a CMS 1500 or UB 92 claim form. These claims are subject to all established requirements for processing directly through the CA-MMIS system. EDS adjudicates claims for services, resulting in one of four possible actions:

1. Paid (claim is paid);
2. Denied (claim is denied);
3. Suspended (EDS staff perform further research); or
4. Additional information is requested (a Resubmission Transmittal Document (RTD) is sent to the provider requesting additional information).

Claims passing all edits and audits are adjudicated daily. EDS forwards a payment tape weekly to the State Controller's office for a checkwrite and the provider is notified through a Remittance Advice Detail form.

WPCS claims are paid through the Department of Social Services (DSS), In-Home Supportive Services (IHSS), Case Management Information Payrolling System (CMIPS), which is developed and managed by EDS.

The CDHS/IHO NE authorizes WPCS service hours by completing a written letter of authorization, that is forwarded to the waiver participant, the WPCS provider, and the CDHS/IHO staff responsible for time cards and payment authorizations. Time cards are mailed to WPCS providers with instructions on

how to report the WPCS hours provided to the waiver participant.

WPCS providers submit monthly timesheets signed by the waiver participant or his/her legal representative/legally responsible adult(s) to the CDHS/IHO Northern Region office for review and approval. The timesheets are reconciled with the hours authorized in accordance with the waiver participant's POT. CDHS/IHO staff access the HCBS benefit section of CMIPS to authorize payment for claimed hours of service, documenting the hours worked, the rate of payment, and the gross amount approved for payment. The CMIPS system generates a payment tape daily that is sent to the State Controller's office where a payroll warrant is issued to the provider.

c. **Certifying Public Expenditures** *(select one)*:

○	**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid:	
	☐	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
	☐	**Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)
X	**No**. Public agencies do not certify expenditures for waiver services.	

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved POT; and, (c) the services were provided:

CDHS/IHO is responsible for prior authorization of all HCBS IHO Waiver services and verification that the requested services are in accordance with the participant's POT.

Claims for waiver services must meet either the CA-MMIS or CMIPS requirements for processing, including program edits and audits. Submitted claims are reviewed to ensure that all required information is present.

Completed claims processed through CA-MMIS are run against system edits and audits to verify:

- Services are prior authorized;
- Participant is a Medi-Cal beneficiary and is enrolled in the HCBS IHO Waiver;
- Satisfactory Medi-Cal eligibility status;
- Provider is an enrolled Medi-Cal HCBS Waiver provider;
- Claim is not a duplicate;
- Claim is paid per the published rates or CDHS/IHO negotiated rate;
- Participant was not institutionalized during the time covered by the claim; and
- Appropriate HCBS IHO Waiver procedure codes.

Completed WPCS claims processed through CMIPS are run against system edits and audits to verify:

- Services are prior authorized;
- Participant is authorized to receive services through IHSS and is enrolled in the HCBS IHO Waiver program;
- Provider is enrolled as an IHSS provider authorized to provide services to the HCBS IHO Waiver participant;
- Claim is not a duplicate;
- Claim does not exceed maximum authorized hours; and
- Participant was not institutionalized during the time covered by the

claim.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

○	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
X	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
	(a) The WPCS waiver benefit is not paid through the CA-MMIS. (b) WPCS provider time sheets are sent to the CDHS/IHO Northern Regional office in Sacramento. CDHS/IHO staff verifies eligibility for WPCS services, the county pay rate, and check the hours submitted for payment against hours authorized. CDHS/IHO staff then calculates a payment amount due to the provider and enters the authorization number and payment information into the WPCS segment of CMIPS. (c) DSS, through an interagency agreement, provides payment to the WPCS providers through CMIPS, a system developed by EDS for use by DSS in processing claims for providers enrolled in the IHSS program. CMIPS captures service evaluation information, issues Notices of Action (NOA), interfaces with the Medi-Cal Eligibility Data System (MEDS), generates management utilization and expenditure reports, and captures claim payment history. The CMIPS system generates a payment tape daily that is sent to the Office of the State Controller where a warrant is issued to the provider. (d) CDHS reimburses DSS for making payments for the authorized WPCS hours under the HCBS IHO Waiver. DSS provides CDHS data tapes for reconciliation of payments for WPCS services. The accuracy and timeliness of payments to WPCS providers are monitored through CMIPS.

○	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements:

X	The Medicaid agency makes payments directly to providers of waiver services.
☐	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
☐	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State Plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

X	**No**. The State does not make supplemental or enhanced payments for waiver services.
○	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe:(a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

○	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
X	**No**. Public providers do not receive payment for waiver services. *Do not complete ItemI-3-e.*

e. Amount of Payment to Public Providers. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

X	The amount paid to public providers is the same as the amount paid to private providers of the same service.
○	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
○	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

X	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
○	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
○	Providers are paid by a managed care entity (or entities) that are paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○	**Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
X	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

○	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
X	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
X	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

X	**Appropriation of State Tax Revenues to the State Medicaid agency**
☐	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

b. **Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

☐	**Appropriation of Local Revenues.** Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
X	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

c. **Information Concerning Certain Sources of Funds**. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources. *Check each that applies.*

☐	Provider taxes or fees
☐	Provider donations
☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
X	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

X	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
○	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

○	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
X`	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

APPENDIX I-7: Participant Co- Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

X	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants:

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver	Amount of	Basis of the Charge

Service	Charge	

iv. **Cumulative Maximum Charges**. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. **Assurance**. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

X	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care:			**Nursing Facility Distinct Part and Subacute**				
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference** (Col. 7 less Col. 4)
WY 1							
NF B-DP	$57,540	$34,029	$91,569	$114,873	$4,053	$118,926	$27,357
NF SA	$84,632	$53,685	$138,317	$251,006	$51,804	$302,810	$164,493
Weighted	**$65,400**	**$38,896**	**$104,296**	**$148,582**	**$15,877**	**$164,459**	**$60,163**
WY 2							
NF B-DP	$58,658	$34,710	$93,368	$117,170	$4,134	$121,304	$27,936
NF SA	$86,334	$54,759	$141,093	$256,026	$52,840	$308,866	$167,773
Weighted	**$66,764**	**$39,675**	**$106,439**	**$151,553**	**$16,195**	**$167,748**	**$61,309**
WY 3							
NF B-DP	$59,833	$35,404	$95,237	$119,513	$4,217	$123,730	$28,493
NF SA	$88,066	$55,854	$143,920	$261,147	$53,897	$315,044	$171,124
Weighted	**$68,102**	**$40,468**	**$108,570**	**$154,584**	**$16,519**	**$171,103**	**$62,533**

Appendix J-2 – Derivation of Estimates

a. **Number Of Unduplicated Participants Served**. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants			
Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care	
		Level of Care:	Level of Care:
		NF DP	**NF SA**
Year 1	210	158	52
Year 2	210	158	52
Year 3	210	158	52
Year 4 (renewal only)	-	-	-
Year 5 (renewal only)	-	-	-

b. **Average Length of Stay**. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

The calculated average length of stay (ALOS) is 365

Assumptions used in calculation:

- CDHS/IHO waiver enrollment experience shows that participants enrolled in a waiver will maintain continuous enrollment until forced to leave due to illness or death.
- The ALOS is expected to remain constant each waiver year.

c. **Derivation of Estimates for Each Factor**. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The Factor D utilization factors for existing waiver services are derived from experience as reported in the CMS 372 reports for the NFA/B and NF SA HCBS waivers. Assumptions used for projecting utilization of new waiver services are described below.

CMS 372 reports used:

- NF AB Waiver
  - WY 3 (January 1, 2003 – December 31, 2003)
  - WY 4 (January 1, 2004 – December 31, 2004)
- NF S/A Waiver
  - WY 2 (April 1, 2003 - March 31, 2004)
  - WY 3 (April 1, 2004 - March 31, 2005)

The following are assumptions used in deriving the Factor D:

- Utilization of Case Management Services is projected to be 100% for waiver participants. All waiver participants receive the constant monitoring and oversight provided through case management services.
- Waiver participants under 21 years of age receive waiver services when like services are not available through the State plan.
- Community Transition Services benefit is capped at a lifetime benefit of $5,000.00.
- Environmental Accessibility Adaptations benefit is capped at a lifetime benefit of $5,000.00.
- The Medical Equipment Operating Expense is limited to that portion of the utility bills directly attributable to operation of life sustaining medical equipment in the participant's place of residence. The minimum monthly amount of reimbursement will be $20.00 a month with a maximum monthly amount of $75.00. For purposes of completing Appendix J-d, an average of $25.00 is used based on reported utilization obtained from the CMS 372 reports.
- The cost of waiver services are projected to increase at two percent per year in accordance with the current California Consumer Price Index, provided the appropriate State of California funding authorities approve the increases.

- The average reimbursement rate for a waiver service is derived from averaging rates of reimbursement for the different providers providing a waiver service.

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor D' estimates for State Plan services are derived from experience as reported in the CMS 372 reports for the NFA/B and NF SA HCBS waivers. Other assumptions used for obtaining the aggregate Factor D', and for each level of care (LOC) described in this waiver are described below.

CMS 372 reports used:

- NF AB Waiver
  - WY 3 (January 1, 2003 – December 31, 2003)
  - WY 4 (January 1, 2004 – December 31, 2004)
- NF S/A Waiver
  - WY 2 (April 1, 2003 - March 31, 2004)
  - WY 3 (April 1, 2004 - March 31, 2005)

The following are assumptions used in deriving the Factor D':

- The cost of all State Plan services furnished in addition to waiver services while the participant was on the waiver, including, but not limited to:
  - State Plan home health services;
  - State Plan personal care services authorized through the county's In Home Supportive Services program;
  - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services;
  - Adult day health care;
  - Short-term institutionalization (hospitalization or Nursing Facility) which began after the participant's first day of waiver services and ended before the end of the waiver year, if the person returned to the waiver.
  - Medical equipment and supplies covered under the State Plan;
  - Non-emergency transportation services covered under the State Plan; and

- Outpatient clinic and physician services covered under the State Plan.

- Factor D' is projected to increase at two percent per year in accordance with the current California Consumer Price Index, and the approval of the State of California funding authorities.
- Medicare Part D drug costs are not included in the Factor D' estimates.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G estimates for inpatient NF Distinct Part and NF subacute LOC are derived from the State's daily institutional costs for 365 consecutive days. Other assumptions used for obtaining the aggregate Factor G, and for each level of care described in this waiver are described below.

CMS 372 reports used:

- NF AB Waiver
  - WY 3 (January 1, 2003 – December 31, 2003)
  - WY 4 (January 1, 2004 – December 31, 2004)
- NF S/A Waiver
  - WY 2 (April 1, 2003 - March 31, 2004)
  - WY 3 (April 1, 2004 - March 31, 2005)
  - WY 2 (July 1, 2004 - June 30, 2005)

The following assumption is used in deriving the Factor G:

Factor G reflects the peer group for participants in this waiver. Participants in the HCBS IHO Waiver have an average LOS of 365 days as these participants have been continuously enrolled in a CDHS/IHO-administered waiver and have been receiving continuous HCBS waivers services since prior to January 1, 2001.

The Factor G (inpatient costs) are projected to increase at two percent per year in accordance with the current California Consumer Price Index, provided the appropriate State of California funding authorities approve the increases.

iv. **Factor G′ Derivation**. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G' estimates for State Plan services utilization during an inpatient NF A/B, NF subacute, and hospital LOC from experience as reported in the CMS 372 reports for the NFA/B, NF SA, and IHMC HCBS waivers. Other assumptions used for obtaining the aggregate Factor G', and for each level of care described in this waiver are described below.

CMS 372 reports used:

- NF AB Waiver
  - WY 3 (January 1, 2003 – December 31, 2003)
  - WY 4 (January 1, 2004 – December 31, 2004)
- NF S/A Waiver
  - WY 2 (April 1, 2003 - March 31, 2004)
  - WY 3 (April 1, 2004 - March 31, 2005)
- IHMC Waiver
  - WY 1 (July 1, 2003 - June 30, 2004)
  - WY 2 (July 1, 2004 - June 30, 2005)

The following are assumptions used in deriving the Factor G':

- The cost of all State Plan services furnished during an inpatient stay.
- Factor G' is projected to increase at two percent per year in accordance with the current California Consumer Price Index, and the approval of the State of California funding authorities.
- Medicare Part D drug costs are not included in the Factor G' estimates.

d. **Estimate of Factor D.** *Select one:* Note: Selection below is new.

X	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. **Estimate of Factor D – Non-Concurrent Waiver**. Complete the following table for each waiver year

Waiver Year: 1					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/Unit**	**Total Cost**
Case Management Services	Hours	210	18	$40.60	$153,468
Community Transition Services	Event	1	1	$5,000.00	$5,000
Environmental Accessibility Adaptations	Event	10	1	$5,000.00	$50,000
Family Training	Hours	24	7	$40.60	$6,821
Habilitation Services	Hours	18	389	$30.68	$214,821
Medical Equipment Operating Expense	Months	10	9	$25.00	$2,250
Personal Emergency Response	Months	2	12	$31.51	$756
PERS Activation/Installation	Event	2	1	$35.00	$70
Private Duty Nursing	Hours	171	2325	$30.25	$12,026,644
Respite - Facility	Days	5	5	$238.57	$5,964
Respite - Home	Hours	14	40	$23.62	$13,227
Transitional Case Management	Hours	1	12	$40.60	$487
Waiver Personal Care Services	Hours	70	1491	$12.02	$1,254,527
GRAND TOTAL:					**$13,734,035**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					210

FACTOR D (Divide grand total by number of participants)	**$65,400**
AVERAGE LENGTH OF STAY ON THE WAIVER	365

Waiver Year: 2					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/Unit**	**Total Cost**
Case Management Services	Hours	210	18	$41.42	$156,568
Community Transition Service	Event	1	1	$5,000.00	$5,000
Environmental Accessibility Adaptations	Event	10	1	$5,000.00	$50,000
Family Training	Hours	24	7	$41.42	$6,959
Habilitation Services	Hours	18	389	$31.30	$219,163
Medical Equipment Operating Expense	Months	10	9	$25.50	$2,295
Personal Emergency Response	Months	2	12	$32.14	$771
PERS Activation/Installation	Event	2	1	$35.70	$71
Private Duty Nursing	Hours	171	2329	$30.86	$12,290,273
Respite - Facility	Days	5	5	$243.34	$6,084
Respite - Home	Hours	14	40	$24.09	$13,490
Transitional Case Management	Hours	1	12	$41.42	$497
Waiver Personal Care Services	Hours	70	1479	$12.26	$1,269,278
GRAND TOTAL:					**$14,020,449**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					210
FACTOR D (Divide grand total by number of participants)					**$66,764**
AVERAGE LENGTH OF STAY ON THE WAIVER					365

Waiver Year: 3					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/Unit**	**Total Cost**
Case Management Services	Hours	210	18	$42.25	$159,705
Community Transition Services	Event	1	1	$5,000.00	$5,000
Environmental Accessibility Adaptations	Event	10	1	$5,000.00	$50,000
Family Training	Hours	24	7	$42.25	$7,098
Habilitation Services	Hours	18	389	$31.92	$223,504
Medical Equipment Operating Expense	Months	10	9	$26.01	$2,341
Personal Emergency Response	Months	2	12	$32.78	$787
PERS Activation/Installation	Event	2	1	$36.41	$73
Private Duty Nursing	Hours	171	2329	$31.48	$12,537,193
Respite - Facility	Days	5	5	$248.20	$6,205
Respite - Home	Hours	14	40	$24.57	$13,759
Transitional Case Management	Hours	1	12	$42.25	$507
Waiver Personal Care Services	Hours	70	1479	$12.51	$1,295,160
GRAND TOTAL:					**$14,301,332**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					210
FACTOR D (Divide grand total by number of participants)					**$68,102**
AVERAGE LENGTH OF STAY ON THE WAIVER					365

Home and Community-Based Services
In-Home Operations Waiver

Standards of Participation

The California Department of Health Services (CDHS)/In-Home Operations (IHO) has established Standards of Participation (SOP) to set forth minimum qualifications for providers of Home and Community Based Services (HCBS) IHO Waiver services.

Note: See Appendix C-3 for a complete description of all HCBS IHO Waiver Services.

List of SOPs:

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CDHS/IHO Waiver Registered Nurse (RN) or Licensed VocationalNurse(LVN) 2

Marriage and Family Therapist (MFT) 10

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Non-Profit Organization 19

Employment Agency **23**

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Home and Community-Based Services Nursing Facility (Congregate Living Health Facility) 27

IHSS Public Authority 34

Note:

Any subsequently enacted or adopted laws or regulations that exceed the IHO Waiver service provider participation requirements shall immediately amend the SOP and the IHO Waiver service provider requirements and shall be applicable to all IHO Waiver service providers, unless DHS deems the foregoing inapplicable, and subject to CMS approval.

Home and Community-Based Services
In-Home Operations Waiver

Standards of Participation

In-Home Operations Waiver
Registered or Licensed Vocational Nurse

Under the HCBS IHO Waiver, the role of the HCBS IHO Waiver Nurse Provider is to provide:

- Case Management (CM) – HCBS IHO Waiver RN only
- Community Transition Service (CTS) - HCBS IHO Waiver RN only
- Environmental Adaptations (EAA) – HCBS IHO Waiver RN only
- Family Training – HCBS IHO Waiver RN only
- Habilitation Services (HS) – HCBS IHO Waiver RN only
- Medical Equipment Operating Expenses (MEOE) - HCBS IHO Waiver RN only
- Private Duty Nursing (PDN) – HCBS IHO Waiver RN and LVN
- Respite Care – HCBS IHO Waiver RN and LVN
- Transitional Case Management (TCM) – HCBS IHO Waiver RN only

1. Definitions:

   a. "HCBS IHO Waiver Nurse Provider " means a Registered Nurse or a Licensed Vocational Nurse (LVN), who provides HCBS IHO Waiver RN or LVN services, as defined in subsection A.2, below, and, in this capacity, is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

      A HCBS IHO Waiver RN or LVN may be a parent, stepparent, foster parent of a minor, a spouse, or legal guardian of the individual only under the following circumstances: there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained by only using this individual. CDHS/IHO may require additional documentation to support requests of this nature. Documentation required before CDHS/IHO can authorize such request, is a written explanation of the attempts made to enlist and retain an HCBS IHO Waiver Nurse Provider, such as a posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not hired or refused employment, if offered.

b. "HCBS IHO Waiver RN or LVN services" means private duty nursing services, as described the in HCBS IHO Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an HCBS IHO Waiver RN or LVN, as defined in subsection A.1, above, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

c. "Private duty nursing services" means services provided by a Registered Nurse or a Licensed Vocational Nurse, which are more individual and continuous than those routinely available through a home health agency as in part-time or intermittent care on a limited basis.

d. "Medi-Cal Consultant" means either a Registered Nurse or Physician, who is licensed to practice in the State and is an employee of CDHS/IHO.

e. "Education and/or training requirements" means any type of formal instruction related to the care needs of the individual for whom services are being requested. Examples of this could include certifications in a particular field, appropriate to the licensure status of the nurse; or continuing education units in the needs of the waiver participant such as wound or pain management.

f. "Evaluation of theoretical knowledge and manual skills" means an assessment conducted by the registered nurse (RN) of the licensed vocational nurse (LVN) in which the LVN is able to demonstrate competency in the provision of skilled nursing services. Examples of this could include having the LVN verbalize requirements for a certain procedure or process; having the RN review a certain task, demonstrate the task and then observing the LVN perform the tasks as prescribed on the POT. This evaluation would need to be documented and provided to CDHS/IHO as indicated.

Requirements of the HCBS IHO Waiver RN:

1. Registered Nurse (RN) acting as the direct care provider:

   a. The initial Treatment Authorization Request (TAR) shall be accompanied by all of the following documentation:

      i. Current license to practice as an RN in the State of California.

ii. Current Basic Life Support (BLS) certification.

iii. Written evidence, in a format acceptable to CDHS/IHO, of training or experience, which shall include at least one of the following:

A. A minimum of 1000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.

B. A minimum of 2000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT.

C. A minimum of 2000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) specified on the TAR and POT.

D. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of CDHS/IHO, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specified on the TAR and POT.

iv. A detailed POT that reflects an appropriate nursing assessment of the waiver participant, interventions, and the **primary care** physician's orders.

A. The appropriateness of the nursing assessment and interventions shall be determined by the Medi-Cal consultant based upon the waiver participant's medical condition and care need(s).

B. The POT shall be signed by the waiver participant, the RN, and the waiver participant's **primary care** physician, and shall contain the dates of service.

v. Signed release form from the waiver participant's **primary care** physician, which shall specify both of the following:

A. The **primary care** physician has knowledge that the RN providing care to the waiver participant is doing so without the affiliation of a home health agency or other licensed health care agency of record.

B. The **primary care** physician is willing to accept responsibility for the care rendered to the waiver participant.

vi. Written home safety evaluation, in a format acceptable to CDHS/IHO that demonstrates that the waiver participant's home environment supports the health and safety of the individual. This documentation shall include all of the following:

A. The area where the waiver participant will be cared for will accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies necessary to maintain the individual in the home in comfort and safety, and to facilitate the nursing care required.

B. Primary and back-up utility, communication, and fire safety systems and devices are installed and available in working order, which shall include grounded electrical outlets, smoke detectors, fire extinguisher, telephone, and notification of utility, emergency, and rescue systems that a person with special needs resides in the home.

C. The home complies with local fire, safety, building, and zoning ordinances, and the number of persons residing in the home does not exceed that permitted by such ordinances.

D. All medical equipment, supplies, primary and back-up systems, and other services and supports, identified in the POT, are in place and available in working order, or have been ordered and will be in place at the time the waiver participant is placed in the home.

vii. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's **primary care** physician within the previous three months for an individual under the age of 21 and within the previous six months for an individual 21 years of age or older. If the last history and physical was completed outside of the respective timeframes, the history and physical shall be accompanied by documentation of the most recent office visit, which shall contain a detailed summary of medical findings that includes a body systems examination.

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

   i. Evidence of renewal of BLS certification and RN licensure prior to expiration.

   ii. Written evidence, in a format acceptable to CDHS/IHO, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.

   iii. Written evidence, in a format acceptable to CDHS/IHO, of on-going contact with the waiver participant's **primary care** physician for the purpose of informing the **primary care** physician of the individual's progress, updating, or revising of the POT, and renewal of physician orders.

   iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated **primary care** physician orders. The updated POT shall be signed by the waiver participant's **primary care** physician, the RN, the waiver participant and will contain the dates of service.

2. RN case manager, waiver service coordinator, transitional case manager, and/or supervisor acting as the supervisor for a HCBS IHO Waiver LVN who is a Licensed Vocational Nurse (LVN):

   a. The initial TAR shall be accompanied by all of the following documentation:

      i. Current license to practice as an RN in the State of California.

      ii. Current BLS certification.

      iii. Written evidence, in a format acceptable to CDHS/IHO, of training or experience, as specified in section B, subsection 1(a)(iii) "requirements of the HCBS IHO Waiver LVN," above.

      iv. Written evidence, in a format acceptable to CDHS/IHO, of training or experience providing case management, service coordination, and/or supervision or delegating nursing care tasks to an LVN or other subordinate staff.

v. Detailed POT, as specified in section B, subsection 1(a)(iv) "requirements of the HCBS IHO Waiver LVN," above.

vi. Written summary, in a format acceptable to CDHS/IHO, of nursing care tasks that have been delegated to the LVN.

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

i. Evidence of renewal of BLS certification and RN licensing prior to expiration.

ii. Written summary, in a format acceptable to CDHS/IHO, of all case management, service coordination and/or supervisory activities which shall include all of the following:

A. Evaluation of the LVN's theoretical knowledge and manual skills needed to care for the individual for whom services have been requested.

B. The training provided to the LVN, as needed, to ensure appropriate care to the waiver participant for whom services have been requested.

C. Monitoring of the care rendered by the LVN, which shall include validation of post-training performance.

D. Any change in the nursing care tasks delegated to the LVN.

E. Evaluation of the case management and/or waiver coordination activities provided.

iii. Written evidence of ongoing contact with the waiver participant's **primary care** physician, as specified in section B., subsection 1(b)(iii), "requirements of the HCBS IHO Waiver RN," above.

iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the HCBS IHO Waiver RN," above.

LVN acting as the direct care provider:

1. The initial TAR shall be accompanied by all of the following documentation:

a. Current license to practice as an LVN in the State of California.

b. Current BLS certification.

c. Name and RN license number of the individual who will be providing ongoing supervision. Such supervision shall be required at a minimum of two hours per calendar month.

d. Written evidence, in a format acceptable to CDHS/IHO, of training or experience, as specified in section B, subsection 1(a)(iii), "requirements of the HCBS IHO Waiver LVN", above.

e. Copy of the detailed POT that reflects the RN nursing assessment of the waiver participant and the **primary care** physician's orders. The POT shall be signed by the supervising RN, the waiver participant's **primary care** physician, the waiver participant, and the LVN.

f. Written home safety evaluation, in a format acceptable to CDHS/IHO, as specified in section B, subsection 1(a)(vi), "requirements of the HCBS IHO Waiver LVN," above.

g. Medical information, as specified in section B., subsection 1(a)(vii), "requirements of the "HCBS IHO Waiver LVN provider," above.

2. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

   a. Evidence of renewal of BLS certification and LVN licensure prior to expiration.

   b. Written evidence, in a format acceptable to CDHS/IHO, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.

   c. Copy of the updated POT that reflects the ongoing RN nursing assessment and updated **primary care** physician**'s** orders. The POT shall be signed by the supervising RN, the waiver participant's **primary care** physician, the waiver participant, and the LVN, and shall contain the dates of service.

3. A TAR or similar request must be approved in advance by CDHS/IHO and shall be required for each HCBS IHO Waiver LVN service request. Initial authorization shall be granted for a period of up to 90 days, and reauthorization shall be granted for periods of up to 180 days.

4. The HCBS IHO Waiver LVN shall agree to notify CDHS/IHO and the waiver participant or his/her legal guardian, in writing, at least thirty (30) days prior to the effective date of termination when the HCBS IHO Waiver LVN intends to terminate home and community-based services waiver, LVN services. This time period may be less than thirty (30) days if there are immediate issues of health and safety for either the nurse or the waiver participant, as determined by the CDHS/IHO.

Home and Community-Based Services
In-Home Operations Waiver

Standards of Participation

Marriage and Family Therapist

A Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a MFT. Under the HCBS IHO Waiver, the role of a MFT as a HCBS IHO Waiver Service Provider is to provide:

- Case Management (CM)
- Community Transition Service (CTS)
- Environmental Accessibility Adaptations (EAA)
- Habilitation Services (HS)
- Medical Equipment Operating Expenses (MEOE)
- Transitional Case Management (TCM)

A MFT who functions as a HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a MFT in the State of California.
2. Have work experience that includes, at least a minimum of 1000 hours experience in providing case management services to the elderly and/or persons with disabilities living in the community.
3. The MFT must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by CDHS/IHO.
4. Provide case management services consistent with the **primary care** physician's orders and the POT as authorized by CDHS/IHO and within the MFT's scope of practice as follows:

a. Develop the POT consistent with the assessment of the waiver participant and the **primary care** physician's orders for care. Collaborate with the waiver participant's **primary care** physician in the development of the POT to ensure the waiver participant's medical care needs are addressed. The POT will identify all of the services rendered to meet the needs of the waiver participant, the providers of those services and the expected outcomes.

b. Within the MFT's scope of practice, facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the **primary care** physician of the waiver participant's status and update or revise the POT as directed by the **primary care** physician to reflect the medical needs of the waiver participant, as

determined by the **primary care** physician. Assist the waiver participant in accessing medical care services that are beyond the MFT's scope of practice. The POT is updated and signed by the **primary care** physician no less frequently than once every six months.

Home and Community-Based Services
In-Home Operations Waiver

Standards of Participation

Licensed Psychologist

A Licensed Psychologist is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the HCBS IHO Waiver, the role of a Licensed Psychologist as a HCBS IHO Waiver Service Provider is to provide:

- Case Management (CM)
- Community Transition Service (CTS)
- Environmental Accessibility Adaptations (EAA)
- Habilitation Services (HS)
- Medical Equipment Operating Expenses (MEOE)
- Transitional Case Management (TCM)

A Licensed Psychologist who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California.
2. Have work experience that includes, at least a minimum of 1000 hours of experience in providing case management services to the elderly and/or persons with disabilities living in the community.
3. The Licensed Psychologist must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by CDHS/IHO.
4. Provide case management services within the scope of practice of a Licensed Psychologist consistent with the **primary care** physician's orders and the POT as authorized by CDHS/IHO as follows:
   a. Develop the POT consistent with the assessment of the waiver participant and the **primary care** physician's orders for care. Collaborate with the waiver participant's **primary care** physician in the development of the POT to ensure the waiver participant's medical care needs are addressed. The POT will identify all of the services rendered to meet the needs of the waiver participant, the providers of those services and the expected outcomes.
   b. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the **primary care** physician of the waiver participant's status and update or

revise the POT as directed by the **primary care** physician to reflect the medical needs of the waiver participant, as determined by the **primary care** physician. Assist the waiver participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice. The POT must be updated and signed by the **primary care** physician no less frequently than once every six months.

Home and Community-Based Services (HCBS)
In-Home Operations Waiver

Standards of Participation

Professional Corporation

A Professional Corporation is a provider that employs individuals who provide services authorized under the HCBS IHO Waiver and is enrolled as an HCBS IHO Waiver Professional Corporation provider in the HCBS IHO Waiver, and meets and maintains the SOP minimal qualifications for a Professional Corporation. Under the HCBS IHO Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:

- Case Management (CM)
- Community Transition Service (CTS)
- Environmental Accessibility Adaptations (EAA)
- Habilitation Services (HS)
- Medical Equipment Operating Expenses (MEOE)
- Transitional Case Management (TCM)

1. The following are the licensed persons permitted to provide the above listed services as Professional Corporations to waiver participants under the terms of the HCBS IHO Waiver:
   a. Licensed Psychologists (See Business and Professions Code section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;
   b. Licensed Clinical Social Workers (LCSW) (See Business and Professions Code section 4996, et seq.); operating a Professional Corporation pursuant to Corporations Code section 13400, et seq., and
   c. Marriage and Family Therapists (MFT) (See Business and Professions Code section 4980, et seq.) operating as a Professional Corporation pursuant to Corporations Code section 13400, et seq.
2. A Professional Corporation who functions as a HCBS IHO Waiver Service Provider shall:
   a. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to Corporations Code section 13400, et seq., or if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation. Good standing of a domestic or foreign professional corporation must be maintained as long as the professional corporation is enrolled as an HCBS

IHO Waiver provider. All Professional Corporations enrolling as HCBS IHO Waiver providers must provide a Certificate of Status of good standing to do business in the State of California (available from the Secretary of State's Office) upon enrollment and provide a current certificate of registration (pursuant to Corporations Code section 13401(b)) provided by the governmental agency regulating the profession. Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the certificate of registration. (Corporations Code section 13401(b)).

b. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.

c. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

   i. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by CDHS/IHO. The professional corporation must notify CDHS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

   ii. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 hours of experience in providing case management services to the elderly and/or persons with disabilities living in the community.

   The Professional Corporation must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by CDHS/IHO.

d. Provide case management services consistent with the **primary care** physician's orders and the POT within the scope of the licensed person's scope of practice as follows:

   i. Develop the POT consistent with the assessment of the waiver participant and the **primary care** physician's orders for care. Collaborate with the waiver participant's **primary care** physician in the development of the

POT to ensure the waiver participant's medical care needs are addressed. The POT will identify all of the services rendered to meet the needs of the waiver participant, the providers of those services, and the expected outcomes; and

ii. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the **primary care** physician of the waiver participant's status and update or revise the POT as directed by the **primary care** physician to reflect the medical needs of the waiver participant, as determined by the **primary care** physician. Assist the waiver participant in accessing medical care services that are beyond the licensed person's scope of practice. The POT must be updated and signed by the **primary care** physician no less frequently than once every six months.

Home and Community-Based Services
In-Home Operations Waiver

Standards of Participation

Licensed Clinical Social Worker

A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the HCBS IHO Waiver, the role of a LCSW as a HCBS IHO Waiver Service Provider is to provide:

- Case Management (CM)
- Community Transition Service (CTS)
- Environmental Accessibility Adaptations (EAA)
- Habilitation Services (HS)
- Medical Equipment Operating Expenses (MEOE)
- Transitional Case Management (TCM)

A LCSW who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a LCSW in the State of California.
2. Have work experience that includes, at least, a minimum of 1000 hours of providing case management services to the elderly and/or persons with disabilities living in the community.
3. The Licensed Clinical Social Worker must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by CDHS/IHO.
4. Provide case management or transitional case management services within the scope of practice of a LCSW consistent with the **primary care** physician's orders and the POT as authorized by CDHS/IHO, as follows:
   a. Develop the POT consistent with the assessment of the beneficiary and the **primary care** physician's orders for care. Collaborate with the beneficiary's **primary care** physician in the development of the POT to ensure the beneficiary's medical care needs are addressed. The POT will identify all of the services rendered to meet the needs of the beneficiary, the providers of those services and the expected outcomes.
   b. Facilitate the process of assessing the beneficiary at the frequency described in the POT for progress and response to the POT. Inform the **primary care** physician of the beneficiary's status and update or revise the POT as directed by the **primary care** physician to reflect the medical needs of the

beneficiary, as determined by the **primary care** physician. Assist the beneficiary in accessing medical care services that are beyond the LCSW's scope of practice. The POT is updated and signed by the **primary care** physician no less frequently than once every six months.

Home and Community-Based Services
In-Home Operations Waiver

Standards of Participation

Non-Profit Organization

A Non-Profit Organization is a California service entity organized and operated under the United States Internal Revenue Code Section 501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBS IHO Waiver SOP and Medi-Cal Provider requirements may provide HCBS IHO Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following HCBS IHO Waiver services:

- Case Management (CM)
- Community Transition Services (CTS)
- Environmental Accessibility Adaptations (EEA)
- Habilitation Services (HS)
- Medical Equipment Operating Expenses (MEOE)
- Personal Emergency Response Systems (PERS)
- Transitional Case Management (TCM)

Minimum qualifications for a Non-Profit Organization functioning as an HCBS IHO Waiver Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program possesses a Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community.
2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.
3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.
4. The Non-Profit Organization shall maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.
5. The Non-Profit Organization is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.
6. The Non-Profit Organization is responsible for providing training and/or in-services to staff eligible to provide HCBS IHO Waiver services and at least

annually reviews the HCBS IHO Waiver services requirements. Training of HCBS IHO Waiver service providers must be specific to the conditions and care of HCBS IHO Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBS IHO Waiver.

8. The Non-Profit Organization is responsible for the maintenance of waiver participant case documentation and financial records which support the claims for waiver services for a minimum period of three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

9. **If the Non-Profit Organization e**mploys licensed persons such as Licensed Clinical Social Worker (LCSW), License Psychologist **and/or** Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, **the licensed professional must meet the following criteria**:

   a. Maintains a current, unsuspended, unrevoked license to practice within his/her scope of licensure in the State of California. The Non-Profit Organization must maintain records of licensing for inspection and review by CDHS/IHO. The Non-Profit Organization must notify CDHS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

   b. **Have** documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM, TCM, CTS, HS, EAA, PERS, and/or MEOE to the elderly and/or persons with disabilities living in the community.

   The Non-Profit Organization must maintain records **and documentation of any and all requirements of the waiver/SOP for inspection and review by CDHS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to CDHS/IHO within 30 days of the change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by CDHS/IHO.**

Home and Community-Based Services
In-Home Operations Waiver

Standards of Participation

Non-Profit Organization

10. Employs qualified professional providers to provide HCBS IHO CM, HS, EAA, PERS, and/or MEOE services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

    a. **Must have** earned **a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy or Gerontology** from an accredited college or university.

    b. Must have at least 1000 hours work experience providing CM, HS, EAA, PERS and/or MEOE services to the elderly and/or persons with disabilities living in the community.

    The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed profession**al** providers for inspection and review by CDHS/IHO.

11. **If the Non-Profit Organization e**mploys qualified unlicensed providers **to provide HS and coordination of EAA only,** who are supervised by an individual with a Baccalaureate degree or higher with 1000 hours experience in providing supervision to providers of services to the elderly and/or persons with disabilities living in the community, **t**he unlicensed providers must meet the following criteria:

    a. **Have at** least an Associate of Arts degree from an accredited college or university and **have** at least 1000 hours work experience in providing services to the elderly and/or persons with disabilities living in the community, **or:**

    b. **Have** two years of experience in providing services to the elderly and/or persons with disabilities living in the community, through an organization or agency.

    The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed **providers** for inspection and review by CDHS/IHO.

12. **The Non-Profit Organization must p**rovide **Case Management** services consistent with the **primary care** physician's orders and the IHO Waiver Plan of Treatment (POT) within the licensed provider's scope of practice and/or the qualified professional's experience as follows:

a. Develop the IHO Waiver POT consistent with the assessment of the participant and the **primary care** physician's orders for care. Collaborate with the participant's **primary care** physician in the development of the POT to ensure the participant's medical care needs are addressed. The POT will identify all of the services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; **and**

b. Facilitate the process of assessing the participant at the frequency described in the POT for progress and response to the POT. Inform the **primary care** physician and/or the case manager of the participant's status to update or revise the POT as directed by the **primary care** physician to reflect the care needs of the participant. Assist the participant in accessing services that are beyond the licensed professional's scope of practice, credentialing, or experience. The POT must be updated and signed by the **primary care** physician no less frequently than once every six months.

Home and Community-Based Services
In-Home Operations Waiver

Standards of Participation

Employment Agency

An Employment Agency is a provider that employs individuals who provide the Waiver Personal Care Services (WPCS), is enrolled as an HCBS IHO Waiver Employment Agency provider in the HCBS IHO Waiver, and meets and maintains the Standards of Participation (SOP) minimal qualifications for an Employment Agency.

Under the HCBS IHO Waiver, the role of the Employment Agency as an HCBS IHO Waiver Service Provider is to provide:

- WPCS.
- Respite

1. The minimal qualifications for the Employment Agency will include:
   a. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.
   b. Must maintain a bond or deposit in lieu of bond in accordance with the Employment Agency, Employment Counseling, and Job Listing Services Act, Title 2.91, Chapters 1-8 (Civil Code section 1812.500 through 1812.544) of the Civil Code ("the Act"), with the California Secretary of State's Office, unless specifically exempted under Title 2.91 of the Civil Code. The Employment Agency shall submit evidence of the filing of its bond prior to enrollment as an HCBS IHO Waiver provider. If a Employment Agency claims exemption from the bond requirements of "the Act", the Employment Agency owner or officer (as authorized by the Employment Agency) shall provide a declaration under penalty of perjury that its operations and/or business do not require the filing of a bond pursuant to the Act and specifically identify the exemption under the Act that applies to the Employment Agency. The declaration under penalty of perjury must also contain the date, place of signature (city or county), and signature of the officer or owner.
   c. Provide training and/or in-services to all its HCBS IHO Waiver providers and provide review training at least annually for a minimum of 8 hours. Training of HCBS IHO Waiver service providers must be specific to the conditions and care of HCBS IHO Waiver beneficiaries served by the agency. This training shall not be reimbursed by this waiver and shall include information in any one or more of the following areas:

- Companionship services
- Activities of daily living
- Basic first aid
- Bowel and bladder care
- Accessing community services
- Basic nutritional care
- Body mechanics

2. Employ individuals who will render HCBS IHO Waiver services to the beneficiaries as authorized by CDHS/IHO and, who meet the following criteria:
   a. Employ individuals who have work experience that includes:
   b. A minimum of 1000 hours of experience within the previous two years in providing companionship, assistance with Activities of Daily Living (ADLs), basic first aid, bowel and bladder care, and assistance with accessing community services to the physically and/or developmentally disabled community.
3. Comply with all pertinent regulations regarding the provision of Personal Care Services under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, section 51183.
4. Comply with all pertinent regulations regarding Personal Care Service Providers under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, section 51204.
5. Comply with all pertinent statutes regarding the Personal Care Services Program as outlined in the Welfare and Institutions Code sections 12300, et seq., 14132.95, and 14132.97.
6. Comply with the terms and conditions provided in the waiver under which the services are provided.

Home and Community-Based Services
In-Home Operations Waiver

Standards of Participation

Personal Care Agency

A Personal Care Agency is a provider that employs individuals who provide Waiver Personal Care Services (WPCS), is enrolled as an HCBS IHO Waiver Personal Care Agency provider in the HCBS IHO waiver, and meets and maintains SOP minimal qualifications for a Personal Care Agency. Under the HCBS IHO Waiver, the role of the Personal Care Agency as an HCBS IHO Waiver Service Provider is to provide:

- WPCS
- Respite care

1. The minimal qualifications for the Personal Care Agency will include:
   a. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.
   b. Must maintain a bond or deposit in lieu of bond in accordance with the Employment Agency, Employment Counseling, and Job Listing Services Act, Title 2.91, Chapters 1-8 (Civil Code section 1812.500 through 1812.544) of the Civil Code, with the Secretary of State's Office, unless specifically exempted under Title 2.91 of the Civil Code. The Personal Care Agency shall submit evidence of the filing of its bond prior to enrollment as an HCBS IHO Waiver provider. If a Personal Care Agency claims exemption from the bond requirements of the Employment Agency, Employment Counseling, and Job Listing Services Act, the Personal Care agency owner or officer shall provide a declaration under penalty of perjury that its operations or business do not require the filing of a bond pursuant to the Employment Agency, Employment Counseling, and Job Listing Services Act and specifically identify the reason why no bond is required. The declaration must also contain the date, place of signature (city or county), and signature of the officer or owner.
2. Provide training and/or in-services to all its HCBS IHO Waiver providers and provide review training at least annually for a minimum of 8 hours. Training of HCBS IHO Waiver service providers must be specific to the conditions and care of HCBS IHO Waiver beneficiaries served by the agency. This training shall not be reimbursed by this waiver and shall include information in any one or more of the following areas:
   - Companionship services

- Activities of daily living
- Basic first aid
- Bowel and bladder care
- Accessing community services
- Basic nutritional care
- Body mechanics

3. Employ individuals who will render Medi-Cal HCBS IHO Waiver services to beneficiaries as authorized by CDHS/IHO and, who meet the following criteria:

   a. Employ individuals who have work experience that includes:

      A minimum of 1000 hours of experience within the previous two years in providing companionship, assistance with Activities of Daily Living (ADLs), basic first aid, bowel and bladder care, and assistance with accessing community services to the physically and/or developmentally disabled community.

   b. The Personal Care Agency must provide and maintain adequate documentation of the minimum hours of work experience for each of its employees for inspection and review by CDHS/IHO.

   c. Comply with all pertinent regulations regarding the provision of Personal Care Services under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, section 51183.

   d. Comply with all pertinent regulations regarding Personal Care Service Providers under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, section 51204.

   e. Comply with all pertinent statutes regarding the Personal Care Services Program as outlined in the Welfare and Institutions Code sections 12300, et seq., 14132.95, and 14132.97.

   f. Comply with the terms and conditions provided in the waiver under which the services are provided.

Home and Community-Based Services
In-Home Operations Waiver

Standards of Participation

Home and Community-Based Services Nursing Facility

Congregate Living Health Facility (CLHF)

The HCBS IHO Waiver program provides services and support to eligible waiver participants who require institutional level of care and choose to receive their medical care services in a home or community setting. As a HCBS IHO Waiver Service Provider, a Congregate Living Health Facility (CLHF) will provide a home like setting for individuals enrolled in the HCBS IHO Waiver who chooses a CLHF as their place of residence. As a HCBS IHO Waiver Service Provider, the CLHF shall meet all applicable licensing standards and will be subject to these HCBS IHO Waiver SOP and will adhere to the documentation, training, and quality assurance requirements identified in the Centers for Medicare & Medicaid Services (CMS) approved waiver.

As a Medi-Cal HCBS IHO Waiver Service Provider, a CLHF waiver provider is a residential facility with a non-institutional, homelike environment, having no more than twelve beds and provides inpatient care that includes the following array of services: medical supervision, 24-hour skilled nursing services and supportive care, pharmacy, dietary, social, recreational and services for waiver participants who meet the medical level of care criteria of the appropriate waiver and are persons whose medical condition(s) are within the scope of licensure for CLHFs as follows: persons who are mentally alert and physically disabled, persons who have a diagnosis of terminal illness, persons who have a diagnosis of a life-threatening illness or persons who are catastrophically and severely disabled. The primary need of CLHF residents shall be the availability of skilled nursing care on a recurring, intermittent, extended, or continuous basis.

1. Legal Authority and Requirements.

   CLHFs shall be licensed in accordance with Health & Safety Code sections 1250(i), 1267.12, and 1267.13, 1267.16, 1267.17, and 1267.19 and shall provide skilled nursing waiver services in accordance with California Code of Regulations (CCR) Title 22 sections 51003 and 51344 and the waiver document.

   CLHFs must be enrolled as a Medi-Cal Waiver provider and shall meet the standards specified in the CCR, Title 22, sections 51200(a), 51000.30 through 51000.55.

Any subsequently adopted laws or regulations that exceed the CLHF waiver provider participation requirements shall supersede the CLHF waiver provider requirements and shall be applicable to all CLHF waiver providers.

2. Physical Plant and Health and Safety Requirements.

   To ensure the health and safety of the HCBS IHO Waiver participant the physical plant of the CLHF shall conform to the H&S Code section 1267.13, as described in part in the following:

   a. Obtain and maintain a valid fire clearance from the appropriate authority having jurisdiction over the facility, based on compliance with state regulations concerning fire and life safety, as adopted by the State Fire Marshall.

   b. The facility shall be in a homelike, residential setting. The facility shall provide sufficient space to allow for the comfort and privacy of each resident and adequate space for the staff to complete their tasks.

   c. Common areas in addition to the space allotted for the residents' sleeping quarters, shall be provided in sufficient quantity to promote the socialization and recreational activities of the residents in a homelike and communal manner.

   d. The residents' individual sleeping quarters will allow sufficient space for safe storage of their property, possessions, and furnishings and still permit access for the staff to complete their necessary health care functions. Not more than two residents shall share a bedroom.

   e. Bathrooms of sufficient space and quantity shall be provided to allow for the hygiene needs of each resident and the ability of the staff to render care without spatial limitations or compromise. No bathroom shall be accessed only through a resident's bedroom.

   f. The facility will be maintained in good repair and shall provide a safe, clean, and healthy environment at all times. All persons shall be protected from hazards throughout the premises.

3. CLHFs Providing HCBS IHO Waiver Services.

As a provider of HCBS IHO Waiver services, a CLHF shall employ a variety of providers and render services as indicated below. The individuals providing waiver services to HCBS IHO Waiver participants shall meet all licensing requirements as specified in California Business and Professions Code and all the standards of participation of the HCBS IHO Waiver. The primary category of service provided by a CLHF is nursing services, which must be available to HCBS IHO Waiver clients on a 24 hours, 7 days a week basis.

4. Nursing Services.

   Pursuant to H&S Code section 1267.13(o)(2)(B) and (o)(2)(C), CLHFs shall provide nursing services provided by a Registered Nurse (RN), Licensed Vocational Nurse (LVN), and a Certified Nurse Assistant (CNA) or equivalent unlicensed provider. There shall be a minimum of two staff members, as describe under a, b, and c awake, alert, and on duty at all times to provide for the residents of the CLHF. At no time, can two CNAs or equivalent

   unlicensed providers be solely responsible for patients, as there must always be a RN or LVN present and "on duty." No nursing personnel shall be assigned housekeeping or dietary duties, such as meal preparation.

   a. Registered Nurse (RN).

      i. A RN will be available on-call to the facility with a response time of thirty minutes or less at all times that a RN is not on the premises.

      ii. The RN shall visit each resident for a minimum of two hours, twice a week, or longer as necessary to meet the resident's patient care needs.

   b. Licensed Vocational Nurse (LVN).

      A LVN shall be in the facility and "on duty" at any time that a RN is not in the facility.

   c. Certified Nurse Assistant (CNA) or equivalent unlicensed provider.

      A CNA or persons with similar training and experience as determined by CDHS/IHO of Health Services (DHS) Licensing and Certification (L&C)

may be available in the facility to assist the skilled nursing staff (RN and LVN) to meet the requirement of two staff members in the facility.

The facility shall provide appropriately qualified staff in sufficient numbers to meet patient care needs.

5. Other Health Related Services.

   a. In addition to the skilled nursing services and pursuant to H&S Code sections 1250(i) and 1267.13, CLHFs will provide or arrange for the following basic services to be provided to individuals enrolled in the HCBS IHO Waiver, as part of the per diem rate paid to CLHF waiver providers: .

      - Medical supervision.
      - Case Management.
      - Pharmacy consultation.
      - Dietary consultation.
      - Social Services.
      - Recreational services.
      - Transportation to and from medical appointments.
      - Housekeeping and laundry services.
      - Cooking and shopping.

   b. H&S Code section 1267.13(o)(3) states, "The facility shall provide appropriately qualified staff in sufficient numbers to meet patient care needs." In addition to nursing care, a facility shall provide professional, administrative, or supportive personnel for the health, safety, and special needs of the patients.

   c. Pursuant to H&S Code section 1267.12, "All persons admitted or accepted for care by the CLHF shall remain under the care of a primary care physician or surgeon who shall see the resident at least every 30 calendar days or more frequently if required by the resident's medical condition."

   d. As a HCBS IHO Waiver service provider, each HCBS IHO Waiver enrolled individual will be assessed for needed or required services as identified by the individual, their legal representative/legally responsible adult(s),

primary care physician, family, caregivers, and/or other individuals at the request of the individual. The CLHF will establish a POT to address how these services will be provided, the frequency of the services and identify the provider for those services that are not included in the CLHFs per diem rate under this waiver. The CLHF will be responsible for arranging for the following services, which may include but are not limited to:

- Counseling services provided by a Licensed Clinical Social Worker;
- Occupational therapy provided by an Occupational Therapist;
- Physical therapy provided by a Physical Therapist;
- Speech therapy provided by a Speech Therapist;
- Education and training of the HCBS IHO Waiver individual to self-direct his/her care needs and/or the education and training of their identified caregivers (who are not CLHF employees) on their care needs;
- Assessment for and repair of Durable Medical Equipment; and
- State Plan Personal Care Services or WPCS as described in the approved HCBS IHO Waiver when off site from the CLHF if such care is not duplicative of care required to be provided to the waiver participant by the CLHF (i.e., not for care to and from medical appointments). State Plan or WPCS providers will not be paid for care that is duplicative of the care being provided by the CLHF.

6. Documentation.

   a. All HCBS IHO Waiver services rendered by the CLHF shall require prior authorization and reauthorization in accordance with CCR Title 22, section 51003.

   b. A Treatment Authorization Request (TAR) shall be prepared by the CLHF and submitted to CDHS/IHO for each waiver participant residing in a CLHF that renders HCBS IHO Waiver services. The initial TAR for each

   c. waiver participant shall be accompanied by a RN developed assessment of care needs, home safety evaluation, and a Plan of Treatment (POT) signed by a **primary care** physician. The initial TAR submitted by the CLHF shall include a copy of the current facility license. TARs submitted for

reauthorization shall be accompanied by an updated **primary care** physician signed POT and a renewed facility license, as appropriate.

d. Each CLHF HCBS IHO Waiver service provider shall maintain a medical record chart for each waiver participant in residence. This medical record shall include documentation regarding all contact made with CLHF professional personnel, current POTs, referral requests and outcomes of said referrals and shall be available to appropriate CDHS/IHO staff for any scheduled or unscheduled visit. All CLHF documentation shall be maintained in compliance with the applicable Federal and State laws, Medi-Cal Provider Standards of Participation, and shall be retained by the CLHF for three years. The CLHF shall also maintain records to document the nursing staff requirements (see Nursing Services above) of these standards of participation have been met and have those records available for inspection or review by CDHS/IHO upon request at any time an enrolled waiver participant is receiving services through a CLHF.

7. Quality Control/Quality Assurance.

   Quality control/quality assurance reviews will be in accordance with the Medi-Cal Operations Division/In-Home Operations (CDHS/IHO) Quality Assurance Plan, as described in the CMS approved waiver.

8. Training Requirements.

   As a licensed CLHF, HCBS IHO Waiver service provider, and pursuant to H&S Code section 1267.13(o)(5), the CLHF shall ensure all CLHF staff receive training regarding care appropriate for each waiver participant's diagnoses and their individual needs. The supervisor(s) of licensed and unlicensed personnel will arrange for the training of their staff to be provided by the CLHF. Provision of the training to CLHF staff is a requirement to be enrolled as a HCBS IHO Waiver provider and is not reimbursed by either Medi-Cal or the HCBS IHO Waiver.

Pursuant to the Policies and Procedures of the CLHF and as a HCBS IHO Waiver provider, each category of nursing (RN, LVN and CNA) shall meet the training requirements to provide the services specified in the POT as allowed

with the respective, scope of practice. CDHS Licensing & Certification will determine if the CLHFs policies and procedures are adequate for the provision of supportive health care services to care for residents, such as those who may be ventilator dependent, require a monitor or other specialized medical equipment as ordered by their **primary care** physician.

As determined by CDHS Licensing & Certification, the CLHF is responsible for the orientation and training of all staff that render care. This includes the review of new and existing CLHF policies and procedures and shall be provided on a quarterly basis. Evidence of quarterly training shall include supporting documentation on the information taught, attendees, and the qualifications of the instructor. Training shall be relevant to the care and type of waiver participant served by the CLHF and enrolled in this waiver.

Home and Community-Based Services
In-Home Operations Waiver

Standards of Participation

In-Home Support Services (IHSS) Public Authority

In-Home Supportive Services (IHSS) Public Authority is a local government agency established by an ordinance enacted by a County Board of Supervisors that is legally separate from the county. The IHSS Public Authority acts as the employer of record for unlicensed IHSS care providers for the purpose of collective bargaining only. The IHSS Public Authority provides a referral list for self-directing consumers to help match unlicensed care providers with recipients seeking personal care services. The IHSS Public Authority may be a HCBS IHO Waiver Public Authority provider in the HCBS IHO Waiver and must meet and maintains SOP minimal qualifications for a Public Authority.

An IHSS Public Authority may provide the following HCBS IHO Waiver services:

- **Waiver Personal Care Services (WPCS)**
- **Habilitation Services**

The minimum qualifications for a IHSS Public Authority functioning as an HCBS IHO Waiver Service Provider are:

1. **Provide training and/or in-services to all its unlicensed providers that is specific to the conditions and care of HCBS IHO Waiver participants. This training shall not be reimbursed by this waiver.**

2. **Comply with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBS IHO Waiver.**

3. **Provide referral listings of individuals who can render Medi-Cal HCBS IHO Waiver services to participants as authorized by CDHS/IHO and who meet the following criteria:**

    - **Comply with all pertinent regulations regarding the provision of Personal Care Services under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, Section 51183.**

Home and Community-Based Services
In-Home Operations Waiver

Standards of Participation

In-Home Support Services (IHSS) Public Authority

- **Comply with all pertinent regulations regarding Personal Care Service Providers under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, Section 51204.**
- **Comply with all pertinent statutes regarding the Personal Care Services Program as outlined in the Welfare and Institutions Code, Sections 12300, et seq., 14132.95, and 14132.97.**

The IHSS Public Authority is required to provide the following services which are part of the State Plan:

- **Maintaining a Registry to match care providers and recipients**
- **Recruiting Registry care providers including criminal background screening and reference checks**
- **Enrolling and orientating all unlicensed care providers**
- **Providing free care provider and recipient training and education**
- **Providing IHSS support, enhancements, and quality assurance (including home visits)**
- **Fostering positive working relationships between recipients and care providers**
- **Assisting recipients with employment issues such as: hiring, creating a work schedule, supervising, and terminating care providers**
- **Coordinating health benefits for care providers that meet the eligibility requirements**