Nursing Facility/Acute Hospital (NF/AH)– Transition and Diversion Waiver

Effective 12/01/2012 – 12/31/2016

Amendment for a §1915 (c) HCBS Waiver
Nursing Facility/Acute Hospital (NF/AH) – Transition and Diversion Waiver
Submitted by:
State of California Department of Health Services

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

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Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **California** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
B. **Program Title:**
Nursing Facility/Acute Hospital (NF/AH) - Transition and Diversion Waiver
C. **Waiver Number:CA.0139**
Original Base Waiver Number: CA.0139.
D. **Amendment Number:CA.0139.R04.01**
E. **Proposed Effective Date:** *(mm/dd/yy)*
12/01/12
Approved Effective Date of Waiver being Amended: 01/01/12

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
California is proposing that the provisions of the Developmentally Disabled/Continuous Nursing Care (DD/CNC) Waiver (CA.0795.R00.00) be merged with the Nursing Facility/Acute Hospital (NF/AH) - Transitions and Diversion Waiver, here after referred to as the NF/AH Waiver. Appropriate changes are proposed to this waiver to facilitate the movement of beneficiaries, providers, and benefits of the DD/CNC Waiver into the NF/AH Waiver.

3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☑ Waiver Application	1, 2, 6 and Att.# 1
☑ Appendix A – Waiver Administration and Operation	QI
☑ Appendix B – Participant Access and Eligibility	1, 2, 3, 6, QI
☑ Appendix C – Participant Services	1, 2, 3, QI
☑ Appendix D – Participant Centered Service Planning and Delivery	1
☑ Appendix E – Participant Direction of Services	1
☐ Appendix F – Participant Rights	
☑ Appendix G – Participant Safeguards	1, 2 ,3, QI
☑ Appendix H	1
☑ Appendix I – Financial Accountability	1, 2, 3, 5, QI
☑ Appendix J – Cost-Neutrality Demonstration	1,2

B. **Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*
☑ **Modify target group(s)**
☐ **Modify Medicaid eligibility**
☑ **Add/delete services**
☑ **Revise service specifications**
☑ **Revise provider qualifications**
☑ **Increase/decrease number of participants**
☑ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☑ **Other**

Specify:
1. Move current DD/CNC Waiver participants into this waiver.
2. Move all current DD/CNC Waiver benefits and services into this waiver.
3. Move DD/CNC provider (ICF/DD-CN) into this waiver as a new NF/AH Waiver provider.
4. Maintain all provisions of the DD/CNC Waiver intact.

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

1. Request Information (1 of 3)

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. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Nursing Facility/Acute Hospital (NF/AH) - Transition and Diversion Waiver

C. Type of Request:amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: CA.0139
Waiver Number:CA.0139.R04.01
Draft ID: CA.16.04.02

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

E. Proposed Effective Date of Waiver being Amended: 01/01/12
Approved Effective Date of Waiver being Amended: 01/01/12

1. Request Information (2 of 3)

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 (*check each that applies*):

☑ **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:
Individuals must meet the criteria for hospital level of care (LOC) for 90 consecutive days or greater and the medical care criteria as described in Appendix B-1.

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility 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-A, NF-B, Pediatric NF-B, NF-B,Distinct Part and NF-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 level of care:
Subcategory: ICF/DD-CN non ventilator dependent and ICF/DD-CN ventilator dependent LOC.

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

- (●) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

- [ ] **Services furnished under the provisions of §1915(a)(1)(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 *(check each that applies):*
  - [ ] **§1915(b)(1) (mandated enrollment to managed care)**
  - [ ] **§1915(b)(2) (central broker)**
  - [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
  - [ ] **§1915(b)(4) (selective contracting/limit number of providers)**
- [ ] **A program operated under §1932(a) of the Act.**

  Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
- [ ] **A program authorized under §1915(i) of the Act.**
- [ ] **A program authorized under §1915(j) of the Act.**
- [ ] **A program authorized under §1115 of the Act.**

  Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

- [x] **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

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 Nursing Facility/Acute Hospital (NF/AH) - Transitions and Diversion Waiver, here after referred to as the NF/AH Waiver, is to provide Medi-Cal beneficiaries with long-term medical conditions who meet one of the designated levels of care in subsection F. above, the option of returning to and/or remaining in in his/her home or home-like community setting in lieu of institutionalization.

The goals of the waiver are to: 1) facilitate a safe and timely transition of Medi-Cal eligible persons from a medical facility to his/her home or community setting utilizing NF/AH Waiver services; 2) offer Medi-Cal eligible persons who reside in the community but are at risk of being institutionalized within the next 30 days, the option of utilizing NF/AH Waiver services to develop a home or community setting program that will safely meet his/her medical care needs; 3) maintain overall cost neutrality so that the costs of the participant's selected NF/AH Waiver and State Plan services do not exceed the Medi-Cal institutional cost at the participant's assessed LOC and necessary facility type.

The DHCS, Long-Term Care Division (LTCD), In-Home Operations (IHO) Branch is responsible for the implementation and monitoring of the NF/AH Waiver. Organizationally, DHCS/IHO has two regional offices. The northern and southern California regional offices are responsible for conducting initial waiver LOC evaluations, LOC reevaluations and ongoing administrative case management activities. Waiver participants must have a current Plan of Treatment (POT) signed by the participant and/or legal representative/legally responsible adult, the participant's primary care physician or designated

physician assistant or nurse practitioner (herein referred to as "primary care physician" or "personal health care provider") and all HCBS waiver providers. The POT describes all the participant's care services, frequency and providers of the identified services to ensure his/her health and safety in a home or community setting.

For those persons meeting the ICF/MR, DD/CNC LOC and who choose to reside in an ICF/DD-CN, the regional center staff will continue to perform an initial screening for waiver participation and LTCD, Community Options Monitoring and Assessment Unit (COMAU) staff will continue with LOC determinations and redeterminations as well as ICF/DD-CN residence reviews.

Waiver services are delivered through 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, non-profit organizations, professional corporations, individual personal care providers, and certain community residential facilities described in Appendix C.

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*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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 Improvement Strategy. Appendix H** contains the Quality Improvement 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)*:

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

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

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **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.
Specify 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, 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. **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 Act (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) age 21 and under and 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 frequency 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 §431.151, 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 §431 Subpart 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 Improvement**. 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 Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
On May 10, 2011 and again on June 8, 2011, DHCS/IHO held stakeholder briefings in Sacramento, CA. An open invitation was posted on the Medi-Cal website to waiver participants, advocates, providers of waiver services, and any other interested party, to provide public comment on the renewal of the NF/AH Waiver. A letter was also sent to all currently active participants on the NF/AH Waiver, inviting them to attend either in person or by telephone, or to submit any questions or comments directly to In-Home Operations by mail, email or telephone.

Ideas were exchanged and questions were answered. DHCS was able to share important information about the NF/AH Waiver and many good ideas were put forward by those attending in person or by telephone. DHCS received a number of recommendations from Disability Rights of California that IHO hopes to incorporate into the NF/AH Waiver as the future allows.

The Department started the public notice process for migration of the DD/CNC Waiver program into the NF/AH Waiver on June 22, 2012, beginning with notification to California Indian Health Programs and Urban Indian Organizations, and DD/CNC Waiver providers and participants. Notice of a public meeting was subsequently posted on June 28 at http://www.dhcs.ca.gov/services/ltc/Pages/DD-CNC.aspx. Information was mailed to NF/AH Waiver participants via USPS in early July.

On July 12, 2012, the Department held a public meeting, in partnership with the Departments of Developmental Services and Public Health. Approximately 20 individuals attended the meeting in-person and 45 individuals participated via the telephone. The department did not receive any objections to the proposed migration of the DD/CNC Waiver into the NF/AH Waiver.

This waiver renewal application also utilized public input received from quarterly public meetings of the Olmstead advisory Committee (OAC), which is a committee convened by the Health and Human Services Agency and made up of consumers, advocates, program managers and service providers for persons who are aged and/or disabled. The OAC uses the following criteria to advise the secretary, Agency staff and Departments about Olmstead issues:

1. Achieves measurable progress towards diverting individuals from institutions and transitioning individuals from less-integrated to more-integrated settings.

2. Fosters and promotes an individual's informed choice in his/her living arrangement, and increases an individual's ability to participate, live and work in the community.

3. Sustains and/or builds upon home and community-bases services and supports, and provides supports and services to all individuals in a culturally and linguistically competent manner.

4. Conforms to the legal rights of persons with disabilities as identified in the Americans with Disabilities act and other state and federal disability civil rights laws.

Along with the public input obtained at the public stakeholder meetings and Olmstead meetings, DHCS/IHO also received and utilized feedback from Independent Living Centers. DHCS/IHO also receives ongoing public input and strives to act on that input in a proactive manner as circumstances allow.

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 is 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:

Last Name: Owen

First Name: Dennis

Title: Chief, In-Home Operations Branch

Agency: Department of Health Care Services

Address: MS 4502, P.O. Box 997413

Address 2: 1501 Capitol Avenue

City: Sacramento

State: **California**

Zip: 95899-7437

Phone: (916) 552-9191 **Ext:** ☐ **TTY**

Fax: (916) 552-9149

E-mail: Dennis.Owen@dhcs.ca.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **California**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Toby Douglas

State Medicaid Director or Designee

Submission Date: Nov 21, 2012

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Douglas

First Name:

Title: Toby

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Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Attachment - #1 Transition Plan

1. Prospective NF/AH Waiver participants who are currently enrolled in the DD/CNC Waiver has been given advance notice of the termination of their current waiver and the opportunity to make an informed decision about their right to choose enrollment in the NF/AH Waiver or institutionalization in a developmental center, subacute facility, acute care facility, or ICF/DD-N.

2. Current DD/CNC Waiver participants will transition to the NF/AH Waiver upon receipt of a signed Freedom of Choice document by IHO and approval of the merged NF/AH and DD/CNC Waivers. The Freedom of Choice document will be signed by the participant prior to the expiration of the current DD/CNC Waiver. This process will be expedited with the assistance of the service providers. All current DD/CNC Waiver participants choosing transition to the NF/AH Waiver will be administratively placed into the NF/AH Waiver with no material change to their eligibility or scope of service. All provisions of the DD/CNC Waiver will be rolled over into the NF/AH Waiver.

3. The DHCS is responsible for establishing accounting activities specific to an HCBS waiver in order to continue to comply with CMS 372 reporting requirements. The Medi-Cal fiscal intermediary will be advised of any changes necessary to maintain smooth adjudication of waiver provider claims. The appropriate Medi-Cal provider manual is in the process of being updated to reflect changes to the program and should be completed within 60 days.

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*):

   ◉ **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)*:

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:
   Health Care Programs, Long-Term Care Division, In-Home Operations Branch
   (Do not complete item A-2)

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   (Complete item A-2-a).

   ○ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

   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-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. 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:
   As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):
   - ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or 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.:*
   - ◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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 (*Select One*):
   - ◉ **Not applicable**
   - ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
     Check each that applies:
     - ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

       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:

Appendix A: Waiver Administration and Operation

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:

Appendix A: Waiver Administration and Operation

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:

Appendix A: Waiver Administration and Operation

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 (*check each that applies*):
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. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency
Participant waiver enrollment	☑
Waiver enrollment managed against approved limits	☑
Waiver expenditures managed against approved levels	☑
Level of care evaluation	☑
Review of Participant service plans	☑
Prior authorization of waiver services	☑
Utilization management	☑
Qualified provider enrollment	☑
Execution of Medicaid provider agreements	☑
Establishment of a statewide rate methodology	☑
Rules, policies, procedures and information development governing the waiver program	☑
Quality assurance and quality improvement activities	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver by exercising oversight of the performance of waiver service delivery function by contracted entities. The percentage of DD/CNC residences reviewed each year.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The percentage of DD/CNC residence Treatment Authorization Requests (TAR) submitted to the Medicaid agency with documentation to support participant LOC determinations.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The DHCS/IHO Quality Assurance Unit (QAU) is responsible for discovery activities as well as analyzing the data collected during those activities. IHO Management and Supervisors will evaluate the findings of the QAU and implement any remediation actions necessary to enhance, correct, and/or improve DHCS/IHO compliance with waiver assurances.

The QAU utilizes the following tools for discovery:

• Internet-based Case Management Information System CMIS);
• Case Record Review;
• Provider Visit Review;
• Event/Issue Database;
• California Medicaid Management Information System (CA-MMIS);
• California Department of Social Services Case Management Information Payrolling System (CMIPS); and,
• Management Information and Decision Support System (MISDSS)

CMIS is a database developed and implemented in 2005. DHCS/IHO uses information from CMIS to establish 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 can provide data on how potential participants are referred to the waiver, how many referrals are received and document the timeliness of the referral, evaluation and enrollment process. CMIS also captures data on applicants who are placed on the waitlist and tracks the reasons active waiver cases are closed. CMIS also allows DHCS/IHO to document the utilization and cost of WPCS, as well as track Notice of Actions (NOA) and captures the number of requests for State Fair Hearings along with the outcomes of those Fair Hearings.

The QAU is responsible for conducting annual Case Record Reviews on active NF/AH 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: www.surveysystem.com/sscalc.htm. The QAU randomly selects 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 indicted by the Sample Size Calculator, the QAU selects the cases for review based upon the corresponding percentage of participants at each level of care (LOC) by DHCS/IHO field office location and ensures that all DHCS Registered Nurses (RN) 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;

• Evidence the participant, and/or his/her legal representative/legally responsible adult(s), and/or circle of support, which includes individuals identified by the participant, are involved in the development of the Plan of Treatment (POT);

• Evidence the POT addresses all the participant's identified needs and assists in assuring the participant's health and welfare;

• Evidence the participant, and/or his/her legal representative/legally responsible adult(s), and circle of support have received instructional information in recognizing abuse, neglect, and exploitation and are knowledgeable in how to report them;

• Evidence the POT reflects all the participant's services are planned and implemented in accordance with their unique needs, expressed preferences, personal goals and abilities while keeping the participant's health status in mind;

• Evidence that information and support is available to help the participant, and/or his/her legal

representative/legally responsible adult(s) and/or circle of support to make selections among service options and providers;

• Evidence the design of the participant's home and community-based program is cost neutral;

• Evidence the POT addresses the need for HCBS healthcare and other services; and

• Evidence the DHCS RN is completing and maintaining the waiver participant's case report in compliance with DHCS/IHO policies and procedures.

The annual Case Record Review also uses the Record Review Tool to document compliance with the assurances provided in the NF/AH Waiver and DHCS/IHO policies and procedures for the Provider Visit Review conducted annually by DHCS RNs. 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 is used to discover if the DHCS staff have conducted timely provider visits, ensures providers meet waiver licensing and certification requirements, provides written feedback to the provider following a provider visit, notifies appropriate agencies of provider issues that affect the health and safety of the waiver participant and documents that the provider has received HCBS waiver training.

The DHCS/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 adults(s), and circle of support's satisfaction with the outcome of the action plan for the reported issue or event. Reports are developed annually and are evaluated for possible remediation actions.

The CA-MMIS, CMIPS and MISDSS databases are used to run utilization and expenditure reports to document that DHCS/IHO is meeting the NF/AH Waiver's cost assurances.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When individual problems/discrepancies are discovered the QAU, DHCS RN Supervisors and IHO Management work together to provide training that would include reviewing program and waiver requirements, ongoing technical assistance to DHCS RN staff, development and implementation of an action plan where required, revision of policies and procedures when necessary, and QAU conducts individual, case by case, follow-up, with the DHCS RN on specific issues to assure the resolution of problems/discrepancies in a timely manner.

Using the tools described above, DHCS/IHO will be able to collect and analyze data for trends and patterns of populations served and document compliance with assurances provided in the NF/AH Waiver. DHCS/IHO can then develop any needed remedial actions deemed necessary to provide the most optimal services to the NF/AH Waiver population while confirming compliance with waiver assurances as well as DHCS/IHO policies and procedures.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups 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:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
○ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
◉ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☑	Medically Fragile	0		☑
	☑	Technology Dependent	0		☑
○ Mental Retardation or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
○ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

For amendment of this waiver, CA is proposing to fold in the waiver participants from the DD/CNC waiver. This new target group will be ICF/MR, ICF/DD-CN LOC, pursuant to Health and Safety Code section 1250(m).

The target criteria for the renewal of this waiver are the same as for the approved waiver. No change is anticipated.

Participants served under the NF/AH waiver will need to have an identified back-up caregiver that is trained in the care of the participant in the event the provider of direct care services is not available for the total number of hours approved and authorized by DHCS. The DHCS RN will assist the participant and/or legal representative/legally responsible adult in identifying a back-up caregiver. Back-up caregivers my consist of community-based organizations, family members, home health agencies, licensed foster parent(s) or any other individual that is part of the participant's circle of support.

The identified back-up caregiver will be identified on the Plan of Treatment (POT). The POT must be signed by the participant's primary care physician, designated physician assistant or nurse practitioner (herein referred to as "primary care physician" or "personal health care provider". For purposes of the NF/AH Waiver, the primary care physician is the physician, that oversees the participant's home program.

Acute Hospital Level of Care (LOC)

The NF/AH 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 (§)14059.5, require services

only available in an acute hospital setting for at least 90 CONSECUTIVE DAYS, pursuant to California Code of Regulations (CCR), Title 22, §51173.1 and meet the criteria as described in CCR, Title 22, § 51344 (a) and (b). Participants to be served under this waiver at the acute level of care (LOC) must be currently receiving medically necessary acute LOC services and in lieu of remaining in, or being admitted to the acute hospital setting, are choosing to remain at home or transition home and continue to receive medically necessary acute LOC services as a participant enrolled in the waiver. All requests for acute hospital LOC waiver services shall meet the criteria as described in this waiver in addition to the criteria set forth in Title 22, CCR, §51344 (a) (b) and 51173.1.

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

Nursing Facility (NF) LOC

This waiver will serve Medi-Cal beneficiaries who would, in the absence of this waiver, and as a matter of medical necessity, pursuant to W&I Code, §14059.5, otherwise require care for 90 consecutive days or greater in an inpatient nursing facility (NF) providing the following types of care:

i. NF Level A – Intermediate Care services pursuant to Title 22, CCR, §51120 and 51334.

ii. NF Level B – Skilled Nursing Facility services pursuant to Title 22, CCR, §51124 and 51335.

iii. NF Subacute Care services, pursuant to Title 22, CCR, §51124.5; or

iv. NF Pediatric Subacute Care 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 CCR and W&I Codes, in addition to those additional criteria outlined in this waiver.

Other NF LOC criteria are:

1. The NF Level B includes three (3) facility types for Medi-Cal reimbursement. The participant must meet the criteria for one of the three (3) facilities listed below, in addition to the other criteria outlined in this waiver.

• Skilled NF, described in Title 22, CCR, §51124 and 51335, and the waiver participant is 21 years of age and older;

• Pediatric NF, described in Title 22, CCR, §51124 and 51335, and the waiver participant is under the age of 21; or,

• Distinct Part (DP) NF, described in Title 22, CCR, §51124 and 51335 and the waiver participant is currently residing in or has been discharged from a DP NF Facility, having spent 30 consecutive days or greater and was referred to the waiver within 90 days after discharge.

2. All requests for NF level waiver services shall meet the criteria set forth in Title 22, CCR, § 51344(a)(c).

ICF/MR, ICF/DD-CN LOC

Pursuant to Health and Safety Code Section 1250(m), waiver-designated criteria.

This population includes individuals who are medically fragile; developmentally disabled infants, children, and adults residing in developmental centers, subacute facilities, acute care facilities, ICF/DD-Ns and in their home who meet the following ICF/DD-CN criteria and choose to receive services in their home or in a community care setting.

1. Have Medi-Cal eligibility.

2. Be determined by a regional center to have a developmental disability as defined by W&I Code section 4512, and eligible for special treatment programs.

3. Be enrolled in a regional center.

4. Be free of clinically active communicable disease reportable under Title 17, CCR section 2500 if choosing to receive services in a community care facility.

5. Have a NF/AH Waiver Freedom of Choice form completed and on file. This form will be completed by the

participant or conservator/legal guardian.

6. Meet the following medical necessity criteria:

a. Participant's condition has stabilized to the point that acute care is not medically necessary; and,

b. Participant's condition warrants the continuous availability of nursing care by a licensed nurse inclusive of nursing assessment, and interventions with documented outcomes; and,

c. Any one of the following:
i. A tracheostomy with dependence on mechanical ventilator not inclusive of CPAP or BiPAP, for the majority of the respiratory effort;

ii. A tracheostomy that requires frequent and/or PRN nursing interventions such as medication administration, suctioning, cleaning inner cannula, changing tracheostomy ties or tube care;

iii. Peritoneal dialysis;

iv. Treatment for pressure sores at stage three or greater, and other wounds requiring sterile technique;

v. Ongoing treatment for multiple health conditions, degenerative disorders, or other complex medical problems requiring skilled nursing observation, assessment and intervention to prevent acute hospital admissions, or as an alternative to c.

d. Administration of at least two treatment procedures listed below:

i. Nasal-tracheal or oral-tracheal suctioning at least every eight hours and room-air mist or oxygen any part of the day;

ii. Tube feeding either continuous drip or bolus every shift;

iii. Five days per week of physical, speech or occupational therapy provided directly by or under the direct supervision of a licensed therapist, funded by the facility at no additional cost to the Medi-Cal program;

iv. Continuous or daily intravenous administration of therapeutic agents, hydration or total parenteral nutrition (TPN) via a peripheral or a central line;

v. Skin care that requires frequent (a minimum of every four hours) skilled nursing observation and intervention with substantiating documentation.

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):*

- (●) **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.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

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)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- **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.**

    Specify the percentage:

  - **Other**

    Specify:

- **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.

  DHCS currently has State approved annual waiver budget expenditure authority for the following institutional alternatives:

  NF-A at $29,548

  NF-B at $48,180

  NF-B, Pediatric at $101,882

  NF-Distinct Part (DP) at $77,600

  NF-Subacute, Adult at $180,219

  NF-Subacute, Pediatric at $240,211

  Acute Hospital at $305,283

  ICF/DD-CN, Non-Ventilator Dependent at $140,678

  ICF/DD-CN, Ventilator Dependent at $155,461

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

  - **The following dollar amount:**

    Specify dollar amount: 0

    The dollar amount *(select one)*

    - **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the 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:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

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:

DHCS/IHO utilizes the following procedures to determine in advance of waiver enrollment that the individual's health and welfare can be assured within the alternative institutional cost limit:

A DHCS Registered Nurse (RN) utilizes the following procedures for waiver participants at the time of enrollment.

1. The DHCS RN schedules a face to face intake visit with the potential waiver participant and an evaluation is completed. The DHCS RN utilizes this evaluation to determine if the participant meets one of the NF/AH Waiver's facility alternative LOC. The DHCS RN documents the type, frequency and amount of waiver and State Plan services the participant is currently receiving or the primary care physician has ordered. The information from the initial visit is documented on the Case Report along with medical justification to support the LOC, alternative 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 the determination of the participant's LOC and the need for services, the DHCS RN provides information to the participant and/or his/her legal representative/legally responsible adult and/or circle of support on the services available through the NF/AH Waiver, the alternative facility type and the waiver's institutional cost limit for the participant's LOC. The DHCS RN works with the participant and/or his/her legal representative/legally responsible adult and/or circle of support, the participant's primary care physician and the NF/AH Waiver Case Manager/Coordinator in identifying the State Plan and NF/AH Waiver services that meet the participant's care needs but do not exceed the participant's institutional alternative cost limit.

3. The type, frequency and amount of the participant's authorized waiver and State plan 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 NF/AH Waiver. The MOHS is a planning instrument used by the participant and/or his/her legal representative/legally responsible adult, circle of support, NF/AH Waiver Case Manager/Coordinator and the DHCS RN to develop a home care program and ensure the cost of the participant's selected services do not exceed the institutional alternative cost limit for their LOC. The MOHS summarizes all the waiver services and provider types available through the NF/AH Waiver. The MOHS enables the participant and/or his/her legal representative/legally responsible adult and/or his/her circle of support to select a combination of waiver and state plan services best suited to meet his/her medical care needs and ensure his/her health and safety.

4. If the cost of the State Plan and NF/AH Waiver services selected by the participant and/or his/her legal representative/legally responsible adult exceed the participant's institutional alternative cost limit and the participant and/or his/her legal representative/legally responsible adult is unwilling to make any changes to the selected services,

DHCS will issue a Notice of Action (NOA) denying enrollment in the NF/AH Waiver due to not meeting the waiver's cost neutrality requirement.

The NF/AH Waiver cost neutrality is calculated using the participant's institutional alternative cost limit for their LOC as described in Appendix B-2 and detailed in Appendix J-1 for the NF A, NF B, NF B Pediatric, NF-DP, NF-Adult Subacute, NF-Pediatric Subacute, Acute Hospital, ICF/DD-CN Non-Ventilator Dependent and ICF/DD-CN Ventilator Dependent levels of care. Increases and adaptations to the institutional alternative cost limits require approval by the California Department of Finance, authorization of appropriations by the State Legislature to support an increase in waiver expenditures and CMS approval to amend the NF/AH Waiver to increase the institutional alternative cost limit.

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 *(check each that applies)*:

☑ **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:

☑ **Other safeguard(s)**

Specify:

When there is a change in the participant's condition or circumstances post entrance to the NF/AH Waiver that requires the provision of services in an amount that exceeds the participant's institutional cost limit, the following safeguards have been established to avoid an adverse impact on the participant while ensuring compliance with the terms of the waiver:

1. If there is a change in the type, frequency or amount of selected waiver or State Plan services that exceed the participant's institutional cost limit the DHCS RN will work with the participant and/or his/her legal representative/legally responsible adult and/or circle of support and NF/AH Waiver Case Manager/Coordinator in identifying services that will meet the participant's health and safety needs and not exceed the participant's institutional cost limit.

2. The participant is reevaluated to determine if he/she meets the criteria for another LOC and/or institutional alternative described in the waiver. Upon determination of a change in the LOC the appropriate institutional cost limit will be used in the MOHS to determine if the cost of the participant's services that will 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 institutional alternative cost limit and the participant does not meet the criteria for another LOC within the NF/AH Waiver the DHCS RN will contact the participant and/or his/her legal representative/legally responsible adult, the participant's NF/AH Waiver Case Manager/Coordinator 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: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

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

Waiver Year	Unduplicated Number of Participants
Year 1	

Waiver Year	Unduplicated Number of Participants
	3276
Year 2	3448
Year 3	3620
Year 4	3792
Year 5	3964

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.**
- ◉ **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	3276
Year 2	3448
Year 3	3620
Year 4	3792
Year 5	3964

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

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)*:

- ○ **Not applicable. The state does not reserve capacity.**
- ◉ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Nursing Facility (NF) A/B Level of Care (LOC) Allocation	
Nursing Facility (NF) Subacute Level of Care (LOC) Allocation	
Individuals Residing in a Facility (NF A/B LOC) Allocation	
Acute Hospital Level of Care (LOC) Allocation	
Intermediate Care Facility for the Developmentally Disabled - Continuous Nursing (ICF/DD-CN) Level of Care (LOC) Allocation	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Nursing Facility (NF) A/B Level of Care (LOC) Allocation

Purpose *(describe):*

Beginning January 1, 2007, the Nursing Facility (NF) A/B Waiver (Control Number 0139) was redesigned and renewed by CMS and renamed the Nursing Facility/Acute Hospital (NF/AH) Waiver. At that time, the NF A/B Waiver, the NF Subacute Waiver (Control Number 0384) and the In-Home Medical Care (IHMC) Waiver (Control Number 0348) were combined.

The NF/AH Waiver was designed to provide services to persons meeting the NF A and B, Subacute and Acute Hospital levels of care. All NF A/B, NF Subacute and IHMC Waiver participants receiving waiver services as of December 31, 2006 were reevaluated and transitioned to the NF/AH Waiver. After all transitions were completed the NF Subacute and IHMC Waivers were terminated.

Based on the waiver slots in the previous waivers, DHCS/IHO allocated a certain number of waiver slots within the NF/AH Waiver for each major LOC (NF A/B, Subacute and Acute Hospital). The slots allocated to the NF A/B LOC started at 1240 and increased by 110 slots on January 1 of each consecutive year. The slots allocated to the Subacute LOC started at 852 and increased by 50 slots on January 1 of each consecutive year and the slots allocated to the Acute Hospital LOC were set at 300 and would remain at that number indefinitely.

Describe how the amount of reserved capacity was determined:

Based on the approved waiver slots in the terminated NF A/B Waiver, DHCS/IHO originally allocated 1240 waiver slots within the NF/AH Waiver for the NF A/B LOC. This allocation has increased by 110 slots each year on January 1 of 2008, 2009, 2010 and 2011. For this renewal of the NF/AH Waiver, 110 slots will again be added to the NF A/B LOC on January 1, 2012 bringing the initial NF A/B slots to 1790. These NF A/B slots have been reduced each year by those slots allocated to individuals transitioning out of a facility at the NF A/B LOC each year bringing the allocated NF A/B slots to 1682.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	1682
Year 2	1813
Year 3	1944
Year 4 (renewal only)	2075
Year 5 (renewal only)	2206

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Nursing Facility (NF) Subacute Level of Care (LOC) Allocation

Purpose *(describe):*

Beginning January 1, 2007, the Nursing Facility (NF) A/B Waiver (Control Number 0139) was redesigned and renewed by CMS and renamed the Nursing Facility/Acute Hospital (NF/AH)

Waiver. At that time, the NF A/B Waiver, the NF Subacute Waiver (Control Number 0384) and the In-Home Medical Care (IHMC) Waiver (Control Number 0348) were combined.

The NF/AH Waiver was designed to provide services to persons meeting the NF A and B, Subacute and Acute Hospital levels of care. All NF A/B, NF Subacute and IHMC Waiver participants receiving waiver services as of December 31, 2006 were reevaluated and transitioned to the NF/AH Waiver. After all transitions were completed the NF Subacute and IHMC Waivers were terminated.

Based on the waiver slots in the previous waivers, DHCS/IHO allocated a certain number of waiver slots within the NF/AH Waiver for each major LOC (NF A/B, Subacute and Acute Hospital). The slots allocated to the NF A/B LOC started at 1240 and increased by 110 slots on January 1 of each consecutive year. The slots allocated to the Subacute LOC started at 852 and increased by 50 slots on January 1 of each consecutive year and the slots allocated to the Acute Hospital LOC were set at 300 and would remain at that number indefinitely.

Describe how the amount of reserved capacity was determined:

Based on the approved waiver slots in the terminated NF Subacute Waiver, DHCS/IHO originally allocated 852 waiver slots within the NF/AH Waiver for the NF Subacute LOC. This allocation has increased by 50 slots each year on January 1 of 2008, 2009, 2010 and 2011. For this renewal of the NF/AH Waiver, 50 slots will again be added to the NF Subacute LOC on January 1, 2012 bringing the initial NF Subacute slots to 1102.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	1102
Year 2	1152
Year 3	1202
Year 4 (renewal only)	1252
Year 5 (renewal only)	1302

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Individuals Residing in a Facility (NF A/B LOC) Allocation

Purpose *(describe):*

A 2007 amendment to the NF/AH Waiver reserved 250 slots for individuals that had been residing in a facility for more than 90 days and would be transitioning out to a home or home-like setting in the community. At the time of this renewal there are 108 slots remaining and most of those slots will be utilized by individuals referred to the NF/AH Waiver through California Community Transitions (CCT), ensuring there is a NF A/B LOC slot available for those individuals if needed. CCT is a program developed to assist Medi-Cal eligible individuals that have been residing in a nursing facility, sub-acute care facility, acute hospital or an Intermediate care facility for persons with developmental disabilities who have resided in a facility for at least six months, to find services and supports that could help them live in a community setting.

The reserve capacity for each waiver year below assumes that the remainder of these slots will be filled by individuals that meet the above criteria during the life of this waiver renewal.

Describe how the amount of reserved capacity was determined:

The reservie capacity was originally set to be in compliance with California W&I Code 14132.99(b).

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	108
Year 2	87
Year 3	66
Year 4 (renewal only)	45
Year 5 (renewal only)	24

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Acute Hospital Level of Care (LOC) Allocation

Purpose *(describe):*

Beginning January 1, 2007, the Nursing Facility (NF) A/B Waiver (Control Number 0139) was redesigned and renewed by CMS and renamed the Nursing Facility/Acute Hospital (NF/AH) Waiver. At that time, the NF A/B Waiver, the NF Subacute Waiver (Control Number 0384) and the In-Home Medical Care (IHMC) Waiver (Control Number 0348) were combined.

The NF/AH Waiver was designed to provide services to persons meeting the NF A and B, Subacute and Acute Hospital levels of care. All NF A/B, NF Subacute and IHMC Waiver participants receiving waiver services as of December 31, 2006 were reevaluated and transitioned to the NF/AH Waiver. After all transitions were completed the NF Subacute and IHMC Waivers were terminated.

Based on the waiver slots in the previous waivers, DHCS/IHO allocated a certain number of waiver slots within the NF/AH Waiver for each major LOC (NF A/B, Subacute and Acute Hospital). The slots allocated to the NF A/B LOC started at 1240 and increased by 110 slots on January 1 of each consecutive year. The slots allocated to the Subacute LOC started at 852 and increased by 50 slots on January 1 of each consecutive year and the slots allocated to the Acute Hospital LOC were set at 300 and would remain at that number indefinitely.

Describe how the amount of reserved capacity was determined:

Based on the approved waiver slots in the terminated IHMC Waiver, DHCS/IHO allocated a total 300 waiver slots within the NF/AH Waiver for the Acute Hospital LOC. That number will remain at this level indefinitely.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	300
Year 2	300
Year 3	300
Year 4 (renewal only)	300
Year 5 (renewal only)	300

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Intermediate Care Facility for the Developmentally Disabled - Continuous Nursing (ICF/DD-CN) Level of Care (LOC) Allocation

Purpose *(describe):*

Beginning January 1, 2007, the Nursing Facility (NF) A/B Waiver (Control Number 0139) was redesigned and renewed by CMS and renamed the Nursing Facility/Acute Hospital (NF/AH) Waiver. At that time, the NF A/B Waiver, the NF Subacute Waiver (Control Number 0384) and the In-Home Medical Care (IHMC) Waiver (Control Number 0348) were combined.

The NF/AH Waiver was designed to provide services to persons meeting the NF A and B, Subacute and Acute Hospital levels of care. All NF A/B, NF Subacute and IHMC Waiver participants receiving waiver services as of December 31, 2006 were reevaluated and transitioned to the NF/AH Waiver. After all transitions were completed the NF Subacute and IHMC Waivers were terminated.

Beginning October 1, 2012 the DD-CNC Waiver (Control Number 0795) will be combined with the NF/AH Waiver (Control Number 0139) adding the ICF/DD-CN level of care to the NF/AH Waiver. All DD-CNC Waiver participants receiving waiver services as of September 30, 2012 will be transitioned to the NF/AH Waiver. After all transitions are completed the DD-CNC Waiver will be terminated.

Based on the waiver slots in the previous waivers, DHCS/IHO allocated a certain number of waiver slots within the NF/AH Waiver for each major LOC (NF A/B, Subacute, Acute Hospital and now ICF/DD-CNC). The slots allocated to the NF A/B LOC started at 1240 and increased by 110 slots on January 1 of each consecutive year. The slots allocated to the Subacute LOC started at 852 and increased by 50 slots on January 1 of each consecutive year. The slots allocated to the Acute Hospital LOC were set at 300 and would remain at that number indefinitely. The slots allocated to the ICF/DD-CN LOC will start at 84 (the number of slots for WY 3 of the DD-CNC Waiver) and will increase by 12 slots on January 1 of each consecutive year.

Describe how the amount of reserved capacity was determined:

Based on the approved waiver slots in the DD-CNC Waiver, DHCS/IHO will add and allocate 84 waiver slots within the NF/AH Waiver for the ICF/DD-CN LOC. This allocation will increase by 12 slots each year on January 1 of 2013, 2014, 2015 and 2016.

With this renewal these slots will further be allocated between ICF/DD-CN Non Ventilator Dependent (75%) and ICF/DD-CN Ventilator Dependent (25%) LOC subject to change as deemed necessary.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	84
Year 2	96
Year 3	108
Year 4 (renewal only)	120
Year 5 (renewal only)	132

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)*:

- (●) **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:

- (●) **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 the maximum unduplicated count of participants enrolled in the NF/AH Waiver will increase up to capacity as described in Appendix B-3: a through c.

Enrollment is based upon a first come first serve process.

An individual requesting NF/AH Waiver services must complete and submit a HCBS Waiver Application to DHCS/IHO. If the application is not complete or additional information is needed to determine LOC the application will be deferred pending receipt of current medical information supporting the individual's skilled care needs and LOC. IHO staff will identify the applicant's potential LOC based on the information provided on the application. If a waiver slot is available at the identified LOC the DHCS RN will schedule a face-to-face meeting to assess the individual for enrollment and provide the applicant and/or legal representative/legally responsible adult with information on the NF/AH waiver. If there are no waiver slots available, applicants who potentially meet the waiver's LOC criteria, will be placed on the waitlist. DHCS will then send a letter confirming receipt of the completed HCBS Waiver Application which will include the effective date of placement on the NF/AH Waiver waitlist.

DHCS will consider a potential waiver participant requesting NF/AH Waiver services to be provided while residing in an ICF/DD-CN residence based on selection through the coordinated efforts of the DDS regional centers and the waiver providers. Before DHCS receives an application, the person must be enrolled in a regional center, determined by the regional center to have a developmental disability as defined by Welfare and Institutions Code §4512, be eligible for special treatment programs, and be free of clinically active communicable diseases reportable under Title 17, California Code of Regulations (CCR) §2500.

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

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

Available waiver slots will be assigned to NF/AH Waiver eligible individuals who are on the waitlist in the following order:

i. Individuals who have been residing in a health care facility for at least 90 days at the time of submission of the HCBS Waiver Application to DHCS.

ii. Individuals residing in the community at the time of submission of the HCBS Waiver Application.

Available waiver slots are filled on a rotating basis from the waitlist, offering the first opportunity for waiver enrollment to an individual at the top of the list of individuals residing in a health care facility for at least 90 days and wishing to transition to the community. The second opportunity for enrollment will be offered to the individual at the top of the list of individuals residing in the community. The third opportunity will be offered to the individual at the top of the list of individuals residing in a health care facility for at least 90 days, and so forth. If an individual is unable to accept or declines waiver enrollment, the open waiver slot will be offered to the next individual in the order of rotation.

DHCS/IHO also works closely with California Community Transitions (CCT), a program developed to assist Medi-Cal eligible individuals that have been residing in a nursing facility, subacute care facility, acute hospital or an intermediate care facility for persons with developmental disabilities who have resided in a facility for at least six months, to find services and supports that could help them live in a community setting. Frequently CCT partners with DHCS/IHO and refers individuals who have successfully transitioned from a facility to the community, and who meet the medical criteria, for enrollment in the NF/AH Waiver.

Priority Enrollment

DHCS/IHO may reserve waiver slots for priority enrollment to prevent interruption of existing home and community-based services or prevent unnecessary nursing facility placement.

Priority enrollment into the NF/AH Waiver is given only to individuals who meet the following criteria:

i. The individual must be a current Medi-Cal beneficiary who will turn 21 years of age during the current waiver year AND must have been receiving or have been authorized for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental private duty nursing services for at least six months prior to his/her 21st birthday; must submit a completed Waiver Application; and must be medically eligible for placement into the NF/AH Waiver, or

ii. This priority enrollment provision is for applicants currently in an acute care hospital setting who would be immediately placed in a Medi-Cal long-term care nursing facility in the absence of waiver services being provided in the home as a diversionary measure.

Within 60 days of notification of an available waiver slot, an individual must schedule a face-to-face evaluation with a DHCS RN to determine eligibility for enrollment. If a face-to-face evaluation is not scheduled within 60 days, or if waiver services are declined when offered, a Notice of Action (NOA) will be sent to the individual and he/she will be removed from the waitlist.

Within 90 days of notification that he/she is eligible for enrollment in the NF/AH Waiver, an individual must identify a waiver service provider and provide DHCS/IHO with a primary care physician-signed POT that meets the requirements outlined in Appendix D. If a primary care physician-signed POT is not received within 90 days, a NOA will be sent to the individual and he/she will be removed from the waitlist and their case will be closed. The individual may submit a new waiver application to IHO at any time.

The 90 day time period will be extended only for individuals who have applied for Medi-Cal where special rules are being applied to determine their Medi-Cal eligibility because of their pending enrollment in the NF/AH Waiver. The individual must continue to actively work with a county eligibility worker and failure to cooperate with the county will be a valid reason to close the pending waiver case.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (●) **No**
   - ( ) **Yes**

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:

  - (●) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

  Specify percentage:

- [ ] **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)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only 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.*
- (●) **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.

- (●) **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**

Check each that applies:

- [ ] **A special income level equal to:**

  Select one:

  - ( ) **300% of the SSI Federal Benefit Rate (FBR)**
  - ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

    Specify percentage: [ ]
  - ( ) **A dollar amount which is lower than 300%.**

    Specify dollar amount: [ ]
- [ ] **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%.**

    Specify percentage amount: [ ]
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

  [ ]

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

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):*

- (●) **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*):

- (●) **Use spousal post-eligibility rules under §1924 of the Act.**
  (Complete Item B-5-b (SSI State) and Item B-5-d)
- ( ) **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
  (Complete Item B-5-b (SSI State). 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-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. 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:

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)**
- ( ) **A percentage of the FBR, which is less than 300%**

  Specify the percentage:
- ( ) **A dollar amount which is less than 300%.**

  Specify dollar amount:
- ( ) **A percentage of the Federal poverty level**

  Specify percentage:
- ( ) **Other standard included under the State Plan**

  Specify:

( ) **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

(●) **The following formula is used to determine the needs allowance:**

Specify:

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.

- **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

- **Not Applicable**
- **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:

Specify the amount of the allowance (*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

Specify 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:**

Specify:

- **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

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:

- (selected) **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

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 and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. 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**
- **A percentage of the Federal poverty level**

  Specify percentage:
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- **The following formula is used to determine the needs allowance:**

  Specify formula:

- **Other**

  Specify:

  An amount which represents the sum of (1) the income standard used to determine eligibility and (2) any amount of income disregarded during the section 1902(a)(10)(A)(ii)(VI) eligibility phase.

ii. **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:

- **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 in 42 §CFR 435.726:**

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:

- **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **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: Participant Access and Eligibility

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 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: 1

ii. **Frequency of services.** The State requires (select one):

- **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*):

- (●) **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**
  Specify:

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:

A Registered Nurse (RN), licensed to practice in the State of California or a physician (M.D. or D.O.) licensed in the State of California will perform the initial evaluation of the NF/AH Waiver applicants utilizing a face-to-face intake home/community visit.

An RN or MD employed by DHCS will make the LOC determination based upon the Case Report completed by the RN or MD/DO during the initial evaluation.

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 level of care (LOC) is determined by criteria established in Title 22, California Code of Regulations (CCR) Division 3, Sections (§)51173.1, 51120, 51124, 51124.5, 51125.6, 51334 and 51335; Health and Safety Code Section 1250(m); as well as information submitted to support medical necessity for the services as defined in Title 22, CCR §51003. Together this information is used during the initial and ongoing reevaluation of all waiver services provided through the NF/AH 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 Welfare & Institutions (W&I) Code §14059, otherwise require care in a health care facility providing the following types of care:

• NF Level A services, pursuant to Title 22, CCR, § 51120 and 51334,

• NF Adult Level B services, pursuant to Title 22, CCR, §51124 and 51335 and the waiver participant is 21 years of age and older,

• NF Pediatric Level B services, pursuant to Title 22, CCR, §51124 and 51335 and the waiver participant is under the age of 21,

• Distinct Part (DP) NF, described in Title 22, CCR, §51124 and 51335 and the waiver participant is currently residing in or has been discharged from a DP facility, having spent 30 consecutive days or greater and was referred to the waiver within 90 days after discharge,

• NF Subacute services, pursuant to Title 22, CCR, §51124.5,

• NF Pediatric Subacute services, pursuant to Title 22, CCR, §51125.6,

• Acute Hospital services, pursuant to Title 22, CCR, §51344 and 51173.1, or

• ICF/MR, ICF/DD-CN services, pursuant to Health and Safety Code, Section 1250(m).

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 DHCS RN Supervisor to determine if the DHCS RN's LOC determination is correct and that the home safety evaluation was performed and completed. The LOC determinations may be reviewed by the DHCS Medical Consultant, a physician licensed to practice in the State of California. On approval of the LOC determination, the Case Report is signed by both the DHCS RN and DHCS RN Supervisor.

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)*:

- (●) **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:

A DHCS RN conducts a complete LOC evaluation/reevaluation of the applicants or participants of waiver services. The initial 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 an individual's need for waiver services, refer to Appendix B Section 1.b. Once the evaluation visit is completed, the DHCS RN 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, caregivers or the DHCS RN. The Case Report also documents plans for resolution of issues identified during the evaluation for waiver enrollment. The DHCS RN 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**
- (●) **Other schedule**

Specify the other schedule:

The DHCS RN 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. NF/AH 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 DHCS RN 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. Level 1 - participants are reevaluated at least once every 365 days. 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, between 270 and 365 days. Participants have minor staffing or durable medical equipment issues and maintains regular contact with the DHCS RN.

c. Level 3 - participants are reevaluated between 180 and 270 days. Participants may 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.

d. Level 4 - participants are reevaluated more frequently than once every 180 days. Participants require frequent monitoring and interventions by the DHCS RN to address issues that affect their health and safety and are at an elevated risk. The DHCS RN conducts frequent on-site visits to work with the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support and the waiver provider responsible for rendering waiver case management services in response to issues requiring a plan of correction and follow-up.

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

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  Specify the qualifications:

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 *(specify):*

Quarterly reports are generated from the CMIS database. The database tracks the date of last evaluation and the date when the participant requires a reevaluation. Quarterly tracking reports are distributed to the DHCS RNs and the DHCS RN 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 §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The LOC evaluation and reevaluation records are maintained in a participant's case record file or in electronically retrievable participant files with the assigned DHCS RN.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

a. *Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of NF/AH Waiver participants who received an initial LOC determination of eligibility indicating the need for institutional care prior to receipt of waiver services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CMIS Database Tracking and Reporting System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of NF/AH Waiver participants who received a timely LOC redetermination within 12 months of their previous or initial LOC evaluation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CMIS Database Tracking and Reporting System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
	☐ **Weekly**	☐ **100% Review**

☑ **State Medicaid Agency**		
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of NF/AH Waiver participant's LOC determinations and redeterminations that are completed accurately by qualified LOC evaluators and are based on waiver criteria as found in Title 22 and supported by appropriate medical documentation.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of NF/AH Waiver participant's LOC determinations that were completed by a DHCS Registered Nurse (RN) with a current license to practice in the State of California and whose qualifications to perform LOC assessments has been validated by specific training based on waiver criteria.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of NF/AH Waiver participant's LOC assessments performed by a DHCS RN that have been reviewed and approved for accuracy by a RN Supervisor.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of inaccurate LOC determinations that were effectively remediated.

Data Source (Select one):
Trends, remediation actions proposed / taken
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Initial Level of Care Evaluation – LOC evaluations are conducted for all applicants and enrolled participants utilizing the tools, procedures, and processes described in Appendix B-6. The QAU utilizes CMIS and the Quality Assurance Case Record Review to monitor the timeliness and accuracy of the LOC initial and re-evaluation determinations.

CMIS captures the data documenting:
• DHCS received the HCBS Waiver Application;
• DHCS reviewed the HCBS Waiver Application;
• The applicant received an evaluation prior to enrollment in the NF/AH Waiver;
• The applicant was enrolled in the NF/AH 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 QAU staff evaluates the accuracy of the LOC determination based on the information documented in the participant's case report.

A DHCS RN is responsible for the evaluation visit and waiver eligibility determination. The DHCS staff consists of registered nurses (RN) and DHCS RN Supervisors. The DHCS RN must submit evidence of the evaluation visit and documentation of the LOC determination to the DHCS RN Supervisor before the applicant is enrolled in the NF/AH Waiver. Only the DHCS RN Supervisor and the QAU are allowed to enter the enrollment information in CMIS. CMIS has an edit that will not allow the participant to be opened to the waiver unless the date of the evaluation visit has been entered. Opening the waiver is documented by entering the date the participant was approved eligible for the NF/AH Waiver.

Re-evaluations of LOC determinations are conducted as described in Appendix B. The DHCS RN is responsible for the timeliness of LOC re-evaluations. QAU uses CMIS to discover the timeliness of the reevaluation LOC determination using the Home Visit Over-Due Report. The 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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The QAU runs a quarterly report that identifies participants who have not had their LOC re-evaluation completed within 60 days of the calculated date for their next visit. These reports are provided to the DHCS RN Supervisors for follow-up with their staff to develop a plan for completing the overdue home visits.

The QAU conducts the annual Case Record Review on a sample of participants who were enrolled in the waiver during the year. The QAU uses the Sample Size Calculator, as previously described, to determine the number of cases for review. The cases selected for review will reflect the percentage of cases for each LOC in the waiver, percentage of cases per DHCS/IHO field office and ensure cases from all DHCS RNs are represented. The DHCS RN uses a Case Management Report form to document their observations, actions and information obtained during the participant's initial and all re-evaluation visits. The DHCS RN documents the participant's medical care needs and the justification of the LOC determination in the Case Management Report and uses the criteria and regulations cited in the NF/AH Waiver in making the LOC determination.

It is IHO's policy that DHCS RN Supervisors review all Case Management Reports. Once the DHCS RN Supervisor has determined the Case Management Report is complete and is in agreement with the LOC determination, the DHCS RN Supervisor signs and dates the case report. If the DHCS RN Supervisor and DHCS RN are not in agreement with the LOC determination the Case Management Report is reviewed by the a DHCS Medical Consultant who is a physician licensed to practice in the State of California. The DHCS Medical Consultant's LOC determination is final and documented in the case report.

The annual Case Record Review is used to discover the DHCS RN level of compliance with completing the Case Management Report and reviews the LOC determinations to determine if they are in compliance with the NF/AH Waiver facility alternatives. Within 90 days of the review, the QAU will present an analysis of the findings to the DHCS/IHO Management Team. Based upon the findings and level of compliance, remediation actions will be developed and implemented within 30 days by the DHCS/IHO Management Team and QAU. Remediation actions may include identification of individual RNs in need of remedial training or correction of systemic issues such as evaluation procedures affecting the accuracy of LOC determinations. Effectiveness of the remediation actions will be monitored by the DHCS RN Supervisors and the QAU will conduct monthly follow-up discovery activities, when necessary, to determine the effectiveness of the remediation actions.

QAU for ICF/DD-CN Residences
1. Issues are discussed with the residence administrator, nurse consultant and other consultants. Technical assistance (TA) is provided.

2. A post-visit letter is sent to the residence administrator identifying the TA that was provided. Issues are identified and documented in the participant case report.

3. Upon completion of the residence visit, the DHCS RN meets with staff to discuss concerns and findings. All findings are documented in the ICF/DD-CN Residence provider file.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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 is:*

i. informed of any feasible alternatives under the waiver; and
ii. 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 representatives) 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 re-evaluations for continued enrollment in the NF/AH Waiver. Information is provided verbally and in writing through use of the “Freedom of Choice“ and “Informing Notice”.

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 NF/AH waiver enrollment, the DHCS RN 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 DHCS RN has described the services available under the NF/AH 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. Waiver services are not authorized for the participant until the signed and accepted “Freedom of Choice” is received by DHCS/IHO. If a signed and accepted "Freedom of Choice" is not received by DHCS/IHO within 30 days of the date the "Freedom of Choice" was mailed to the participant, enrollment in the NF/AH Waiver will be considered "Declined" and the case will be closed.

b. **Maintenance of Forms.** Per 45 CFR §92.42, 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 "Freedom of Choice" form is maintained in the participant's case record file at the designated DHCS IHO office.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency 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, DHCS 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

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *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:*

Service Type	Service		
Statutory Service	**Case Management/Coordination**		
Statutory Service	**Habilitation Services**		
Statutory Service	**Home Respite**		
Statutory Service	**Waiver Personal Care Services (WPCS)**		
Other Service	**Community Transition Services**		
Other Service	**Continuouse Nursing and Supportive Services**		
Other Service	**Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services**		
Other Service	**Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services**		
Other Service	**Environmental Accessibility Adaptations**		
Other Service	**Facility Respite**		
Other Service	**Family/Caregiver Training**		
Other Service	**Medical Equipment Operating Expense**		
Other Service	**Personal Emergency Response (PERS) Installation and Testing**		
Other Service	**Personal Emergency Response Systems (PERS)**		
Other Service	**Private Duty Nursing - Including Home Health Aide and Shared Services**		
Other Service	**Transitional Case Management**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Case Management/Coordination

Service Definition *(Scope):*

Case Management/Coordination services are designed to assess the participant and determine their need for medical, psycho-social, 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/Coordinators also assist in acquiring personal care providers as described in the participant's plan of care.

Case Managers/Coordinators 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 individual, and in the development and updating of the participant's primary care physician-signed POT. Case Managers/Coordinators 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/Coordination responsibilities include assessing, care planning, locating, coordinating, and monitoring services for community-based participants on the waiver. Case Management/Coordination services do not include the direct delivery of any service.

HCBS RN providers providing Case Management/Coordination services also supervise, monitor, and train HCBS LVN providers of private duty nursing services. Waiver participants may select Case Management/Coordination 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

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Professional Corporation
Agency	Non-Profit Agency
Individual	HCBS Benefit Provider – Licensed Clinical Social Worker (LCSW)
Individual	HCBS Benefit Provider – Marriage and Family Therapist (MFT)
Agency	Home Health Agency (HHA) – Registered Nurse (RN)
Individual	HCBS Waiver Nurse Provider – Registered Nurse (RN)
Individual	HCBS Benefit Provider - Licensed Psychologist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management/Coordination

Provider Category:
Agency
Provider Type:
Professional Corporation
Provider Qualifications
License *(specify):*
CC §13401(b)
Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide services authorized under the NF/AH Waiver and is enrolled as an HCBS Waiver Professional Corporation provider, and meets and maintains the SOP minimal qualifications for a Professional Corporation. Under the HCBS NF/AH Waiver, the role of the Professional Corporation is to permit its licensed employees

within the scope of their practice to provide:

• Case Management/Coordination (CM/C)
• 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 NF/AH 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 NF/AH 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 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 DHCS/IHO. The professional corporation must notify DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management/Coordination

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business license, appropriate for the services purchased.

Certificate *(specify):*

Other Standard *(specify):*

Non-Profit Agency

A Non-Profit Agency/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 NF/AH Waiver SOP and Medi-Cal Provider requirements may provide NF/AH Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following NF/AH 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)
• Home Respite
• Waiver Personal Care Services (WPCS)

Minimum qualifications for a Non-Profit Organization functioning as an NF/AH 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, or

have at least 5 years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

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 NF/AH Waiver services and at least annually reviews the NF/AH Waiver services requirements. Training of NF/AH Waiver service providers must be specific to the conditions and care of NF/AH 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 NF/AH 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 employs 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.
b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM/C, 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 DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/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 DHCS/IHO.

10. Employs qualified professional providers to provide NF/AH Waiver CM/C, CTS, HS, EAA, PERS, TCM 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, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM 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 professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation, which may include activities commonly described as peer mentoring, or WPCS, they must be

supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing 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, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have a 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, or

c. Have one year experience as a Peer Mentor/Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or 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 DHCS/IHO.

12. The Non-Profit Organization must provide Case Management/Coordination services consistent with the participant's choice and interests, the primary care physician's orders and the NF/AH 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 NF/AH Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest and the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interest and medical care needs are addressed. The POT will identify all the choices and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and

b. Facilitate the process of collaboration and assessment with 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/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and 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 participant and primary care physician no less frequently than once every six months.

c. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney general's Registry of Charitable Trusts

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management/Coordination

Provider Category:

Individual

Provider Type:
HCBS Benefit Provider – Licensed Clinical Social Worker (LCSW)
Provider Qualifications
License *(specify):*
BPC §§4990-4998.7
Title 16, §§1870-1881
Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the NF/AH Waiver the role of a LCSW as a NF/AH 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 NF/AH 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 DHCS/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 DHCS/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.

Verification of Provider Qualifications
Entity Responsible for Verification:
California Board of Behavioral Sciences
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management/Coordination

Provider Category:
Individual
Provider Type:
HCBS Benefit Provider – Marriage and Family Therapist (MFT)
Provider Qualifications
License *(specify):*
HCBS Benefit Provider – Marriage and Family Therapist (MFT)
BPCBPC §§4980-4989
Title 16, §§1829-1848
Certificate *(specify):*

Other Standard *(specify):*
A Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a MFT. Under the NF/AH Waiver, the role of a MFT as a NF/AH 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 NF/AH 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 DHCS/IHO.

4. Provide case management services consistent with the primary care physician's orders and the POT as authorized by DHCS/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.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:
Marriage and Family Therapist
California Board of Behavioral Sciences
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management/Coordination

Provider Category:
Agency
Provider Type:
Home Health Agency (HHA) – Registered Nurse (RN)
Provider Qualifications
License *(specify):*
HHA Title 22 §§74659 et seq.
RN BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
CDPH Licensing and Certification
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management/Coordination

Provider Category:
Individual
Provider Type:
HCBS Waiver Nurse Provider – Registered Nurse (RN)
Provider Qualifications
License *(specify):*
HCBS Registered Nurse (RN)
BPC §§ 2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4
Certificate *(specify):*

Other Standard *(specify):*

Under the HCBS NF/AH Waiver, the role of the NF/AH Waiver Registered Nurse (RN) provider is to provide:
• Case Management
• Community Transition Service
• Environmental Adaptations
• Family Training
• Habilitation Services
• Medical Equipment Operating Expenses
• Private Duty Nursing
• Respite Care
• Transitional Case Management
1.Definitions:
a. "NF/AH Waiver Nurse Provider" means a Registered Nurse who provides NF/AH Waiver RN services, as defined in subsection b. 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.

To ensure the health, safety, and well-being of the vulnerable NF/AH Waiver population, a NF/AH Waiver Nurse Provider application will not be processed should it be determined through official documentation that the professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal,California or another State's licensing agency; or has been subject to any disciplinary action or currently in or pending an investigation for the following types of complaints:
• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual,violent,or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

A NF/AH Waiver RN 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. IHO may require additional documentation to support requests of this nature. Documentation required before IHO can authorize such a request, is a written explanation of the attempts made to enlist and retain an NF/AH 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. "NF/AH Waiver RN services" means private duty nursing services, as described the in NF/AH Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an NF/AH Waiver RN, as defined in subsection a. above and c. below, 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, 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 DHCS.

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 DHCS/IHO as indicated.

Requirements of the NF/AH 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, unencumbered 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 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 DHCS/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 DHCS/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. This should include a diagram of the participant's home.

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 begins receiving services.
vii. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's 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 unencumbered RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/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 DHCS/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 primary care physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated 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 NF/AH Waiver LVN who is a Licensed Vocational Nurse (LVN):

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current, unencumbered license to practice as an RN in the State of California.
ii. Current BLS certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, as specified in section B, subsection 1(a)(iii) "requirements of the NF/AH Waiver LVN", above.
iv. Written evidence, in a format acceptable to DHCS/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 NF/AH Waiver LVN", above.
vi. Written summary, in a format acceptable to DHCS/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 unencumbered RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/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 NF/AH Waiver RN", above.

iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the NF/AH Waiver RN", above.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing

Frequency of Verification:

Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management/Coordination

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - Licensed Psychologist

Provider Qualifications

License *(specify):*

BPC §§2909 et seq.
Title 16, §§1380 et seq

Certificate *(specify):*

Other Standard *(specify):*

HCBS NF/AH Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the NF/AH Waiver, the role of a Licensed Psychologist as a 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 NF/AH 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 DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Board of Psychology
Frequency of Verification:
Biennially

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Statutory Service

Service:
Habilitation

Alternate Service Title (if any):
Habilitation Services

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 and are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. 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

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**

☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	HCBS Benefit Provider – Marriage and Family Therapist (MFT)
Individual	HCBS Benefit Provider – Licensed Psychologist
Agency	Professional Corporation
Individual	HCBS Waiver Nurse Provider – Registered Nurse (RN)
Individual	HCBS Benefit Provider – Licensed Clinical Social Worker (LCSW)
Agency	Non-Profit Agency
Agency	Home Health Agency (HHA) – Registered Nurse (RN)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Habilitation Services

Provider Category:
Individual

Provider Type:
HCBS Benefit Provider – Marriage and Family Therapist (MFT)

Provider Qualifications

License *(specify):*
BPCBPC §§4980-4989
Title 16, §§1829-1848

Certificate *(specify):*

Other Standard *(specify):*
A Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a MFT. Under the NF/AH Waiver, the role of a MFT as a NF/AH 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 NF/AH 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 DHCS/IHO.

4. Provide case management services consistent with the primary care physician's orders and the POT as authorized by DHCS/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.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Board of Behavioral Sciences
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Habilitation Services

Provider Category:
Individual
Provider Type:
HCBS Benefit Provider – Licensed Psychologist
Provider Qualifications

License *(specify):*
BPC §§2909 et seq.
Title 16, §§1380 et seq.
Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the NF/AH Waiver, the role of a Licensed Psychologist as a 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 NF/AH 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 DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Board of Psychology
Frequency of Verification:
Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Habilitation Services

Provider Category:
Agency
Provider Type:
Professional Corporation
Provider Qualifications

License *(specify):*
CC §13401(b)
Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide services authorized under the NF/AH Waiver and is enrolled as an HCBS Waiver Professional Corporation provider, and meets and maintains the SOP minimal qualifications for a Professional Corporation. Under the HCBS NF/AH Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:

• Case Management/Coordination (CM/C)
• 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 NF/AH 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 NF/AH 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 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 DHCS/IHO. The professional corporation must notify DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Habilitation Services

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider – Registered Nurse (RN)

Provider Qualifications

License *(specify):*

BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4

Certificate *(specify):*

Other Standard *(specify):*

Under the HCBS NF/AH Waiver, the role of the NF/AH Waiver Registered Nurse (RN) provider is to provide:

• Case Management
• Community Transition Service
• Environmental Adaptations
• Family Training
• Habilitation Services
• Medical Equipment Operating Expenses
• Private Duty Nursing
• Respite Care
• Transitional Case Management

1.Definitions:

a. “NF/AH Waiver Nurse Provider” means a Registered Nurse who provides NF/AH Waiver RN services, as defined in subsection b. 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.

To ensure the health, safety, and well-being of the vulnerable NF/AH Waiver population, a NF/AH Waiver Nurse Provider application will not be processed should it be determined through official documentation that the professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal,California or another State’s licensing agency; or has been subject to any disciplinary action or currently in or pending an investigation for the following types of complaints:

• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual,violent,or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license

• RNs on probation and have violated their probation conditions

A NF/AH Waiver RN 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. IHO may require additional documentation to support requests of this nature. Documentation required before IHO can authorize such a request, is a written explanation of the attempts made to enlist and retain an NF/AH 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. "NF/AH Waiver RN services" means private duty nursing services, as described the in NF/AH Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an NF/AH Waiver RN, as defined in subsection a. above and c. below, 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, 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 DHCS.

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 DHCS/IHO as indicated.

Requirements of the NF/AH 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, unencumbered 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 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 DHCS/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 DHCS/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. This should include a diagram of the participant's home.

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 begins receiving services.

vii. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's 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 unencumbered RN licensure prior to expiration.

ii. Written evidence, in a format acceptable to DHCS/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 DHCS/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 primary care physician orders.

iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated 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 NF/AH Waiver LVN who is a Licensed Vocational Nurse (LVN):

a. The initial TAR shall be accompanied by all of the following documentation:

i. Current, unencumbered license to practice as an RN in the State of California.

ii. Current BLS certification.

iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, as specified in section B, subsection 1(a)(iii) "requirements of the NF/AH Waiver LVN", above.
iv. Written evidence, in a format acceptable to DHCS/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 NF/AH Waiver LVN", above.
vi. Written summary, in a format acceptable to DHCS/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 unencumbered RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/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 NF/AH Waiver RN", above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the NF/AH Waiver RN", above.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Board of Registered Nursing
Frequency of Verification:
Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Habilitation Services

Provider Category:
Individual
Provider Type:
HCBS Benefit Provider – Licensed Clinical Social Worker (LCSW)
Provider Qualifications

License *(specify):*
Licensed Clinical Social Worker (LCSW)
BPC §§4990-4998.7
Title 16, §§1870-1881
Certificate *(specify):*

Other Standard *(specify):*

HCBS NF/AH Waiver Standards of Participation

A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the NF/AH Waiver the role of a LCSW as a NF/AH 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 NF/AH 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 DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Behavioral Sciences

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Habilitation Services

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business license, appropriate for the services purchased
Certificate *(specify):*

Other Standard *(specify):*
Non-Profit Agency
A Non-Profit Agency/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 NF/AH Waiver SOP and Medi-Cal Provider requirements may provide NF/AH Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following NF/AH 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)
• Home Respite
• Waiver Personal Care Services (WPCS)

Minimum qualifications for a Non-Profit Organization functioning as an NF/AH 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, or have at least 5 years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

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 NF/AH Waiver services and at least annually reviews the NF/AH Waiver services requirements. Training of NF/AH Waiver service providers must be specific to the conditions and care of NF/AH 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 NF/AH 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 employs 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.
b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM/C, 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 DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/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 DHCS/IHO.

10. Employs qualified professional providers to provide NF/AH Waiver CM/C, CTS, HS, EAA, PERS, TCM 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, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM 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 professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation, which may include activities commonly described as peer mentoring, or WPCS, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing 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, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have a 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, or

c. Have one year experience as a Peer Mentor/Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or 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 DHCS/IHO.

12. The Non-Profit Organization must provide Case Management/Coordination services consistent with the participant's choice and interests, the primary care physician's orders and the NF/AH 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 NF/AH Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest and the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interest and medical care needs are addressed. The POT will identify all the choices and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and

b. Facilitate the process of collaboration and assessment with 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/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and 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 participant and primary care physician no less frequently than once every six months.
c. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Attorney General's registry of Charitable Trusts
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Habilitation Services

Provider Category:
Agency
Provider Type:
Home Health Agency (HHA) – Registered Nurse (RN)
Provider Qualifications

License *(specify):*
HHA Title 22, §§74659 et seq.
RN BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DPH Licensing and Certification
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Statutory Service
Service:

Respite

Alternate Service Title (if any):
Home Respite
Service Definition *(Scope):*
The Home Respite benefit is intermittent or regularly scheduled 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 DHCS/IHO.

Waiver participants whose complex medical care needs meet the acute hospital facility LOC, requiring frequent evaluation by a licensed provider(s) who is skilled in and knowledgeable in evaluating the participant's medical needs and administering technically complex care as ordered by the participant's primary care physician are not eligible to receive Home Respite services provided by an unlicensed provider. This requirement is consistent with the California Business and Professions Code, section 2725 et seq.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
DHCS/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), Private Duty Nursing (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.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency (HHA) – Certified Home Health Aide (CHHA)
Individual	HCBS Waiver Nurse Provider – Registered Nurse (RN)
Agency	Personal Care Agency
Agency	Home Health Agency (HHA) – Licensed Vocational Nurse (LVN)
Agency	Employment Agency
Agency	Home Health Agency (HHA) – Registered Nurse (RN)
Individual	HCBS Waiver Nurse Provider – Licensed Vocational Nurse (LVN)
Individual	Waiver Personal Care Service (WPCS) Provider
Agency	Non-Profit Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:
Agency
Provider Type:
Home Health Agency (HHA) – Certified Home Health Aide (CHHA)
Provider Qualifications
License *(specify):*
HHA Title 22, §§74659 et seq.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DPH Licensing and Certification
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:
Individual
Provider Type:
HCBS Waiver Nurse Provider – Registered Nurse (RN)
Provider Qualifications
License *(specify):*
BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4
Certificate *(specify):*

Other Standard *(specify):*
Under the HCBS NF/AH Waiver, the role of the NF/AH Waiver Registered Nurse (RN) provider is to provide:
• Case Management
• Community Transition Service
• Environmental Adaptations
• Family Training
• Habilitation Services
• Medical Equipment Operating Expenses
• Private Duty Nursing
• Respite Care
• Transitional Case Management
1.Definitions:

a. “NF/AH Waiver Nurse Provider” means a Registered Nurse who provides NF/AH Waiver RN services, as defined in subsection b. 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.

To ensure the health, safety, and well-being of the vulnerable NF/AH Waiver population, a NF/AH Waiver Nurse Provider application will not be processed should it be determined through official documentation that the professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal,California or another State’s licensing agency; or has been subject to any disciplinary action or currently in or pending an investigation for the following types of complaints:
• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual,violent,or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

A NF/AH Waiver RN 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. IHO may require additional documentation to support requests of this nature. Documentation required before IHO can authorize such a request, is a written explanation of the attempts made to enlist and retain an NF/AH 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. “NF/AH Waiver RN services” means private duty nursing services, as described the in NF/AH Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an NF/AH Waiver RN, as defined in subsection a. above and c. below, 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, 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 DHCS.

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 DHCS/IHO as indicated.

Requirements of the NF/AH 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, unencumbered 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 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 DHCS/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 DHCS/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. This should include a diagram of the participant's home.

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 begins receiving services.
vii. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's 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 unencumbered RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/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 DHCS/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 primary care physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated 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 NF/AH Waiver LVN who is a Licensed Vocational Nurse (LVN):

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current, unencumbered license to practice as an RN in the State of California.
ii. Current BLS certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, as specified in section B, subsection 1(a)(iii) "requirements of the NF/AH Waiver LVN", above.
iv. Written evidence, in a format acceptable to DHCS/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 NF/AH Waiver LVN", above.
vi. Written summary, in a format acceptable to DHCS/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 unencumbered RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/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 NF/AH Waiver RN", above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the NF/AH Waiver RN", above.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing

Frequency of Verification:

Biennially

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:
Agency
Provider Type:
Personal Care Agency
Provider Qualifications
License *(specify):*
California Business License
Certificate *(specify):*

Other Standard *(specify):*
County IHSS Program Standards & NF/AH Waiver Standards of Participation

A Personal Care Agency is a provider that employs individuals who provide Waiver Personal Care Services (WPCS), is enrolled as an NF/AH Waiver Personal Care Agency provider in the NF/AH waiver, and meets and maintains SOP minimal qualifications for a Personal Care Agency. Under the NF/AH Waiver, the role of the Personal Care Agency as an NF//AH 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 NF/AH 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 NF/AH Waiver providers and provide review training at least annually for a minimum of 8 hours. Training of NF/AH Waiver service providers must be specific to the conditions and care of NF/AH Waiver participants 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 NF/AH Waiver services to beneficiaries as authorized by DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:

Agency

Provider Type:

Home Health Agency (HHA) – Licensed Vocational Nurse (LVN)

Provider Qualifications

License *(specify):*

HHA Title 22 §74659 et seq.
LVN BPC §§2859-2873.7
Title 22, §51069

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:
Agency
Provider Type:
Employment Agency
Provider Qualifications
License *(specify):*
California Business License
Certificate *(specify):*

Other Standard *(specify):*
County IHSS Program Standards & NF/AH Waiver Standards of Participation

An Employment Agency is a provider that employs individuals who provide the Waiver Personal Care Services (WPCS), is enrolled as an NF/AH Waiver Employment Agency provider in the NF/AH Waiver, and meets and maintains the Standards of Participation (SOP) minimal qualifications for an Employment Agency.

Under the NF/AH Waiver, the role of the Employment Agency as an NF/AH 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 NF/AH 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 NF/AH Waiver providers and review training at least annually for a minimum of 8 hours. Training of NF/AH Waiver service providers must be specific to the conditions and care of NF/AH Waiver participants 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 NF/AH Waiver services to the participants as authorized by DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:

Agency

Provider Type:

Home Health Agency (HHA) – Registered Nurse (RN)

Provider Qualifications

License *(specify):*

HHA Title 22, §§74659 et seq.
RN BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:
Individual
Provider Type:
HCBS Waiver Nurse Provider – Licensed Vocational Nurse (LVN)
Provider Qualifications
License *(specify):*
BPC §§2859-2873.7
Title 22, §51069;
Certificate *(specify):*

Other Standard *(specify):*
NF/AH Waiver Standards of Participation

Under the NF/AH Waiver, the role of the HCBS Waiver Nurse Provider – Licensed Vocation Nurse (LVN) is to provide:

• Private Duty Nursing (PDN)
• Respite Care

1. Definitions:
a. "HCBS Waiver Nurse Provider – Licensed Vocational Nurse (LVN)" means a LVN who provides HCBS Waiver LVN services, as defined in subsection b., 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.

To ensure the health, safety, and well-being of the vulnerable NF/AH Waiver population, a NF/AH Waiver Nurse Provider application will not be processed should it be determined through official documentation that the professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal, California or another State's licensing agency; or has been subject to any disciplinary action or currently in or pending an investigation for the following types of complaints:

• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual, violent, or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• LVNs on probation and have violated their probation conditions

A HCBS Waiver 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. DHCS/IHO may require additional documentation to support requests of this nature. Documentation required before DHCS/IHO can authorize such request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as 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 Waiver LVN services” means private duty nursing services, as described the in NF/AH Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an HCBS Waiver LVN, as defined in subsection a, above, and subsection c, below, 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 LVN, 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. “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.

Requirements of the HCBS Waiver LVN:

LVN acting as the direct care provider:
1. The initial TAR shall be accompanied by all of the following documentation:

a. Current unemcumbered 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 DHCS/IHO, of training or experience, as specified in section B, subsection 1(a)(iii), “requirements of the HCBS 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 DHCS/IHO, as specified in section B, subsection 1(a)(vi), “requirements of the HCBS Waiver LVN,” above.

g. Medical information, as specified in section B., subsection 1(a)(vii), “requirements of the “HCBS 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 DHCS/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 DHCS/IHO and shall be required for each HCBS 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 Waiver LVN shall agree to notify DHCS/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 Waiver LVN intends to terminate HCBS, 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 DHCS/IHO.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Vocational Nursing and Psychiatric Technicians

Frequency of Verification:

Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:

Individual

Provider Type:

Waiver Personal Care Service (WPCS) Provider

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

Other Standard *(specify):*

County IHSS Program Standards & HCBS NF/AH Waiver Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS Nurse Evaluator

Frequency of Verification:

Every 6 months

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business license, appropriate for the services purchased

Certificate *(specify):*

Other Standard *(specify):*

Non-Profit Agency

A Non-Profit Agency/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 NF/AH Waiver SOP and Medi-Cal Provider requirements may provide NF/AH Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following NF/AH 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)
• Home Respite
• Waiver Personal Care Services (WPCS)

Minimum qualifications for a Non-Profit Organization functioning as an NF/AH 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, or have at least 5 years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

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 NF/AH Waiver services and at least annually reviews the NF/AH Waiver services requirements. Training of NF/AH Waiver service providers must be specific to the conditions and care of NF/AH 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 NF/AH 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 employs 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.
b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM/C, 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 DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/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 DHCS/IHO.

10. Employs qualified professional providers to provide NF/AH Waiver CM/C, CTS, HS, EAA, PERS, TCM 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, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM 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 professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation, which may include activities commonly described as peer mentoring, or WPCS, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing 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, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have a 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, or

c. Have one year experience as a Peer Mentor/Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or 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 DHCS/IHO.

12. The Non-Profit Organization must provide Case Management/Coordination services consistent with the participant's choice and interests, the primary care physician's orders and the NF/AH 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 NF/AH Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest and the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interest and medical care needs are addressed. The POT will identify all the choices and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and
b. Facilitate the process of collaboration and assessment with 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/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and 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 participant and primary care physician no less frequently than once every six months.
c. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's registry of Charitable Trusts

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Waiver Personal Care Services (WPCS)

Service Definition *(Scope):*

The Waiver Personal Care Service (WPCS) was established by legislation in 1998 through Assembly Bill (AB) 668 which added Section 14132.97 to the Welfare and Institutions (W&I) Code. WPCS 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 separate page for WPCS provider signatures may be attached to a POT provided by a Home Health Agency.

W&I Section 14132.97 (d)(4) affords an IHSS Public Authority the option of enrolling as a WPCS waiver provider. DHCS is working collaboratively with the California Public Authority Association and the California Department of Social Services (CDSS) to make this option available. In Home Supportive Services (IHSS) Public Authorities will be established as a waiver provider through an amendment to this waiver at the appropriate time.

A waiver participant must be enrolled in and receiving personal care services through the federally funded State Plan Personal Care program so as to ensure the participant's State Plan Personal Care benefit is exhausted prior to receiving WPCS through the NF/AH Waiver.

Waiver participants whose complex medical care needs meet the acute hospital facility level of care (LOC), requiring frequent evaluation and/or intervention by a Registered Nurse (RN) or Licensed Vocational Nurse (LVN) who is skilled and knowledgeable in evaluating the participant's medical needs and administering technically complex care as ordered by the participant's primary care physician, will not be eligible for this service. This requirement is compliant with the California Business and Professions Code, section 2725.

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, 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. To help maintain a 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. 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 DHCS NE, for the initial and reauthorization of services.

• The WPCS Benefit While Participant is Admitted to a Health Care Facility: WPCS providers may be paid while the participant is admitted to 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 (7) 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 to 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 to a health care facility, the WPCS provider must submit written documentation to DHCS/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.).

While 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 or 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 home; and

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

WPCS providers will not be paid for care that duplicates the care that is required to be provided by the health care facility during the participant's admission. This type of care 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 as a WPCS provider who is not otherwise employed by an employment agency, personal care agency, home health agency, IHSS Public Authority, or non-profit organization and is an individual who is employed directly by the Medi-Cal participant receiving WPCS services under the waiver.

Individuals 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 and be enrolled as a provider of Personal Care Services through IHSS.

2. An Employment Agency, as defined in the NF/AH Waiver Standards of Participation (SOP);

3. A Personal Care Agency, as defined in the NF/AH 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 providing WPCS services to a waiver participant shall meet the same definition of and criteria for participation as required for participation in the Medi-Cal program. A HHA providing WPCS services shall be reimbursed for WPCS services as provided pursuant to the waiver.

6. A Non-Profit Agency as defined by the NF/AH Waiver SOP

To ensure the health, safety and welfare of waiver participants, WPCS providers must be awake, alert and present during the scheduled hours of service and immediately available to the participant. Participants authorized for more than 360 hours a month of combined State Plan and/or WPCS benefits, 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 individual enrolled as a WPCS provider must submit a written summary with his/her signed Time Report to DHCS/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.

In the event of an overpayment for any reason, the amount of the overpayment will be deducted from future warrants. If the individual is no longer a WPCS provider, the State reserves the right to pursue payment directly from the individual provider for the amount due.

Non-Profit Organizations, Personal Care Agencies, Employment Agencies, Home Health Agencies, and Non-Profit Agencies providing WPCS must submit a Treatment Authorization Request (TAR) and a POT to DHCS/IHO for prior authorization of WPCS. The TAR and POT must be signed by a representative of the agency submitting the TAR and the waiver participant's primary care physician.

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

DHCS/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, pediatric day health care, In-Home Supportive Services (IHSS), Private Duty Nursing (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.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency (HHA) Personal Care Provider
Agency	Personal Care Agency
Agency	Employment Agency
Agency	Non-Profit Agency
Individual	Waiver Personal Care Service (WPCS) Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Waiver Personal Care Services (WPCS)

Provider Category:

Agency

Provider Type:

Home Health Agency (HHA) Personal Care Provider
Provider Qualifications
License *(specify):*
HHA Title 22 §74659 et seq.
Certificate *(specify):*

Other Standard *(specify):*
County IHSS Program Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
DPH Licensing and Certification
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Waiver Personal Care Services (WPCS)

Provider Category:
Agency
Provider Type:
Personal Care Agency
Provider Qualifications
License *(specify):*
California Business License
Certificate *(specify):*

Other Standard *(specify):*
County IHSS Program Standards & NF/AH Waiver Standards of Participation

A Personal Care Agency is a provider that employs individuals who provide Waiver Personal Care Services (WPCS), is enrolled as an NF/AH Waiver Personal Care Agency provider in the NF/AH waiver, and meets and maintains SOP minimal qualifications for a Personal Care Agency. Under the NF/AH Waiver, the role of the Personal Care Agency as an NF//AH 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 NF/AH 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 NF/AH Waiver providers and provide review training at least annually for a minimum of 8 hours. Training of NF/AH Waiver service providers must be specific to the conditions and care of NF/AH Waiver participants 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 NF/AH Waiver services to beneficiaries as authorized by DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Waiver Personal Care Services (WPCS)

Provider Category:

Agency

Provider Type:

Employment Agency

Provider Qualifications

License *(specify):*

California Business License

Certificate *(specify):*

Other Standard *(specify):*
County IHSS Program Standards & NF/AH Waiver Standards of Participation

An Employment Agency is a provider that employs individuals who provide the Waiver Personal Care Services (WPCS), is enrolled as an NF/AH Waiver Employment Agency provider in the NF/AH Waiver, and meets and maintains the Standards of Participation (SOP) minimal qualifications for an Employment Agency.

Under the NF/AH Waiver, the role of the Employment Agency as an NF/AH 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 NF/AH 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 NF/AH Waiver providers and review training at least annually for a minimum of 8 hours. Training of NF/AH Waiver service providers must be specific to the conditions and care of NF/AH Waiver participants 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 NF/AH Waiver services to the participants as authorized by DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Waiver Personal Care Services (WPCS)

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business license, appropriate for the services purchased

Certificate *(specify):*

Other Standard *(specify):*

Non-Profit Agency

A Non-Profit Agency/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 NF/AH Waiver SOP and Medi-Cal Provider requirements may provide NF/AH Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following NF/AH 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)
• Home Respite
• Waiver Personal Care Services (WPCS)

Minimum qualifications for a Non-Profit Organization functioning as an NF/AH 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, or have at least 5 years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

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 NF/AH Waiver services and at least annually reviews the NF/AH Waiver services requirements. Training of NF/AH Waiver service providers must be specific to the conditions and care of NF/AH 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 NF/AH 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 employs 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.
b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM/C, 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 DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/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 DHCS/IHO.

10. Employs qualified professional providers to provide NF/AH Waiver CM/C, CTS, HS, EAA, PERS, TCM 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, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM 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 professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation, which may include activities commonly described as peer mentoring, or WPCS, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing 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, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have a 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, or

c. Have one year experience as a Peer Mentor/Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or 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 DHCS/IHO.

12. The Non-Profit Organization must provide Case Management/Coordination services consistent with the participant's choice and interests, the primary care physician's orders and the NF/AH 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 NF/AH Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest and the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interest and medical care needs are addressed. The POT will identify all the choices and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and
b. Facilitate the process of collaboration and assessment with 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/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and 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 participant and primary care physician no less frequently than once every six months.
c. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's registry of Charitable Trusts

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Waiver Personal Care Services (WPCS)

Provider Category:

Individual

Provider Type:

Waiver Personal Care Service (WPCS) Provider

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

Other Standard *(specify):*
County IHSS Program Standards & HCBS NF/AH Waiver Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
DHCS Nurse Evaluator
Frequency of Verification:
Every 6 months

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Community Transition Services
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 diversionary/recreational purposes.

The DHCS NE will adjudicate the TAR after all requested documentation has been received and reviewed, the provider overseeing the administration of the service submits all of the medical documentation and invoices for authorization and reimbursement.

The lifetime maximum allowed cost for Community Transition Services is $5,000.00. The DHCS 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. The only exception to the $5,000.00 total maximum is if the participant is compelled to move to a new home through

circumstances beyond his/her control and Community Transition Services are necessary to ensure the health, welfare and safety of the participant, and without which the participant would be unable to move to a new home and would then require reinstitutionalization.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Professional Corporation
Agency	Non-Profit Agency
Agency	Home Health Agency (HHA) – Registered Nurse (RN)
Individual	HCBS Waiver Nurse Provider – Registered Nurse (RN)
Individual	HCBS Benefit Provider – Licensed Psychologist
Individual	HCBS Benefit Provider – Marriage and Family Therapist (MFT)
Individual	HCBS Benefit Provider – Licensed Clinical Social Worker (LCSW)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Agency
Provider Type:
Professional Corporation
Provider Qualifications
License *(specify):*
CC §13401(b)
Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide services authorized under the NF/AH Waiver and is enrolled as an HCBS Waiver Professional Corporation provider, and meets and maintains the SOP minimal qualifications for a Professional Corporation. Under the HCBS NF/AH Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:

• Case Management/Coordination (CM/C)
• 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 NF/AH 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 NF/AH 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 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 DHCS/IHO. The professional corporation must notify DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business license, appropriate for the services purchased

Certificate *(specify):*

Other Standard *(specify):*

Non-Profit Agency

A Non-Profit Agency/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 NF/AH Waiver SOP and Medi-Cal Provider requirements may provide NF/AH Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following NF/AH 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)
• Home Respite
• Waiver Personal Care Services (WPCS)

Minimum qualifications for a Non-Profit Organization functioning as an NF/AH 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, or have at least 5 years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

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 NF/AH Waiver services and at least annually reviews the NF/AH Waiver services requirements. Training of NF/AH Waiver service providers must be specific to the conditions and care of NF/AH 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 NF/AH 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 employs 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.
b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM/C, 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 DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/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 DHCS/IHO.

10. Employs qualified professional providers to provide NF/AH Waiver CM/C, CTS, HS, EAA, PERS, TCM 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, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM 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 professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation, which may include activities commonly described as peer mentoring, or WPCS, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing 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, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have a 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, or

c. Have one year experience as a Peer Mentor/Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or 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 DHCS/IHO.

12. The Non-Profit Organization must provide Case Management/Coordination services consistent with the participant's choice and interests, the primary care physician's orders and the NF/AH 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 NF/AH Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest and the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interest and medical care needs are addressed. The POT will identify all the choices and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and
b. Facilitate the process of collaboration and assessment with 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/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and 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 participant and primary care physician no less frequently than once every six months.
c. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Attorney General's registry of Charitable Trusts
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Agency
Provider Type:
Home Health Agency (HHA) – Registered Nurse (RN)
Provider Qualifications

License *(specify):*
HHA Title 22, §§74659 et seq.
RN BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DPH Licensing and Certification
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Individual
Provider Type:
HCBS Waiver Nurse Provider – Registered Nurse (RN)
Provider Qualifications

License *(specify):*
BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4
Certificate *(specify):*

Other Standard *(specify):*
Under the HCBS NF/AH Waiver, the role of the NF/AH Waiver Registered Nurse (RN) provider is to provide:
• Case Management
• Community Transition Service
• Environmental Adaptations
• Family Training
• Habilitation Services
• Medical Equipment Operating Expenses
• Private Duty Nursing
• Respite Care
• Transitional Case Management
1.Definitions:
a. “NF/AH Waiver Nurse Provider” means a Registered Nurse who provides NF/AH Waiver RN services, as defined in subsection b. 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.

To ensure the health, safety, and well-being of the vulnerable NF/AH Waiver population, a NF/AH Waiver Nurse Provider application will not be processed should it be determined through official documentation that the professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal,California or another State’s licensing agency; or has been subject to any disciplinary action or currently in or pending an investigation for the following types of complaints:
• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual,violent,or abusive offenses
• Fraud or theft offenses

• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

A NF/AH Waiver RN 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. IHO may require additional documentation to support requests of this nature. Documentation required before IHO can authorize such a request, is a written explanation of the attempts made to enlist and retain an NF/AH 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. "NF/AH Waiver RN services" means private duty nursing services, as described the in NF/AH Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an NF/AH Waiver RN, as defined in subsection a. above and c. below, 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, 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 DHCS.

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 DHCS/IHO as indicated.

Requirements of the NF/AH 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, unencumbered 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 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 DHCS/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 DHCS/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. This should include a diagram of the participant's home.

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 begins receiving services.
vii. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's 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 unencumbered RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/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 DHCS/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 primary care physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated 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 NF/AH Waiver LVN who is a Licensed Vocational Nurse (LVN):

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current, unencumbered license to practice as an RN in the State of California.
ii. Current BLS certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, as specified in section B, subsection 1(a)(iii) "requirements of the NF/AH Waiver LVN", above.
iv. Written evidence, in a format acceptable to DHCS/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 NF/AH Waiver LVN", above.
vi. Written summary, in a format acceptable to DHCS/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 unencumbered RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/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 NF/AH Waiver RN", above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the NF/AH Waiver RN", above.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Board of Registered Nursing
Frequency of Verification:
Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Individual
Provider Type:
HCBS Benefit Provider – Licensed Psychologist
Provider Qualifications
License *(specify):*
BPC §§2909 et seq.
Title 16, §§1380 et seq.
Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the NF/AH Waiver, the role of a Licensed Psychologist as a 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 NF/AH 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 DHCS/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 DHCS/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.

Verification of Provider Qualifications
Entity Responsible for Verification:
California Board of Psychology
Frequency of Verification:
Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Individual
Provider Type:
HCBS Benefit Provider – Marriage and Family Therapist (MFT)
Provider Qualifications

License *(specify):*
BPCBPC §§4980-4989
Title 16, §§1829-1848
Certificate *(specify):*

Other Standard *(specify):*
A Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a MFT. Under the NF/AH Waiver, the role of a MFT as a NF/AH 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 NF/AH 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 DHCS/IHO.

4. Provide case management services consistent with the primary care physician's orders and the POT as authorized by DHCS/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.

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.

Verification of Provider Qualifications
Entity Responsible for Verification:
California Board of Behavioral Sciences
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Individual

Provider Type:
HCBS Benefit Provider – Licensed Clinical Social Worker (LCSW)
Provider Qualifications

License *(specify):*
BPC §§4990-4998.7
Title 16, §§1870-1881
Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the NF/AH Waiver the role of a LCSW as a NF/AH 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 NF/AH 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 DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Board of Behavioral Sciences
Frequency of Verification:
Annually

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Continuouse Nursing and Supportive Services

Service Definition *(Scope):*

Continuous Nursing and Supportive Services (CNSS) are provided to waiver participant's residing in a Home and Community-Based Continuous Care Facility (HCBCCF) and must be available to waiver participants 24 hours a day, 7 days a week. The HCBCCF waiver provider, licensed as a Congregate Living Health Facility (CLHF), is a residential facility with a non-institutional, homelike environment and is an alternative setting for individuals that require institutional level of care but choose to receive their medical services in a home or community setting.

CNSS are a collection of services included in a per diem rate based on the waiver participant's level of care. CNSS will include nursing services provided by a Registered Nurse (RN), Licensed Vocational Nurse (LVN), and a Certified Nurse Assistant (CNA) or equivalent unlicensed provider. As part of the per diem rate there must be a minimum of at least a CNA (or unlicensed equivalent provider) and LVN, awake, alert, and on duty at all times to provide for the residents of the HCBCCF. At no time, can two CNAs or equivalent unlicensed providers be solely responsible for waiver participants, 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).

1. A RN will be available on-call to the HCBCCF with a response time of thirty minutes or less at all times that a RN is not on the premises.
2. The RN shall visit each waiver participant for a minimum of two hours, twice a week, or longer as necessary to meet the participant's care needs.

B. Licensed Vocational Nurse (LVN).

1. A LVN shall be in the HCBCCF and "on duty" at any time that a RN is not onsite.

C. Certified Nurse Assistant (CNA) or equivalent unlicensed provider.

1. A CNA or persons with similar training and experience may be available in the HCBCCF to assist the skilled nursing staff (RN and LVN) to meet the requirement of at least 2 staff members awake, alert and on duty at all times to provide for residents of the HCBCCF.

The CNSS per diem rate will also include:

- 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

IHO will not authorize additional waiver services that are duplicative of services included in the CNSS per diem rate.

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

IHO will at no time authorize direct care services or any combination of direct care services exceeding 24 hours of care per day under this waiver. Direct care is hands on care to support the care needs of the waiver participant.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home and Community-Based Continuous Care Facility (HCBCCF) [Congregate Living Health Facility (CLHF)]

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Continuouse Nursing and Supportive Services

Provider Category:
Agency

Provider Type:
Home and Community-Based Continuous Care Facility (HCBCCF) [Congregate Living Health Facility (CLHF)]

Provider Qualifications

License *(specify):*
HSC §§1250et seq.
Title 22, §§51246 et seq.

Certificate *(specify):*

Other Standard *(specify):*
NF/AH Waiver Standards of Participation
As a NF/AH Waiver Service Provider, the HCBCCF operating as a CLHF will provide a home like setting for individuals enrolled in the NF/AH Waiver who chooses a CLHF as their place of residence. As a Waiver Service Provider, the CLHF shall meet all applicable licensing standards and will be subject to the Waiver SOP and will adhere to the documentation, training, and quality assurance requirements identified in the approved waiver.
As a Medi-Cal Waiver Service Provider, a CLHF as a HCBCCF 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 a CLHF 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
A CLHF 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.
A CLHF 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 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. A CLHF Providing Waiver Services
A CLHF shall employ a variety of providers and render services as indicated below. The individuals providing waiver services to Waiver participants shall meet all licensing requirements as specified in California Business and Professions Code and all the SOP of the NF/AH Waiver. The primary category of service provided by a CLHF is nursing services, which must be available to 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), a CLHF 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 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, a CLHF will provide or arrange for the following basic services to be provided to individuals enrolled in the 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 Waiver service provider, each NF/AH 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 CLHF's 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 Waiver participant 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 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 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 IHO for each waiver participant residing in a CLHF that renders Waiver services. The initial TAR for each waiver participant shall be accompanied by a RN developed assessment of care needs, home safety evaluation, and a 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.

c. Each CLHF 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 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 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 Long-Term Care Division/In-Home Operation's Quality Assurance Plan, as described in the approved waiver.

8. Training Requirements

As a licensed CLHF 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 Waiver provider and is not reimbursed by either Medi-Cal or the Waiver.

Pursuant to the Policies and Procedures of the CLHF and as a 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. DHCS Licensing & Certification (L&C) 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 L&C, 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Biennially

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services

Service Definition *(Scope):*

DD/CNC, Non-Ventilator Dependent Services are provided to waiver participants who require 24-hour personal care, developmental services, and nursing supervision, are non-ventilator dependent and are developmentally disabled. Waiver participants must be certified by a physician as requiring continuous skilled nursing care. Waiver participants who are ventilator dependent may not receive DD/CNC, Non-Ventilator Dependent Services.

Such individuals have chosen to reside in an Intermediate Care Facility for the Developmentally Disabled – Continuous Nursing (ICF/DD-CN) and services must be available to waiver participants 24 hours a day, 7 days a week. NF/AH participants who choose to receive waiver services in a setting other than an ICF/DD-CN may not receive DD/CNC, non-ventilator dependent services.

ICF/DD-CN residential facilities have non-institutional, homelike environments and are an alternative setting for developmentally disabled individuals that require an institutional level of care but choose to receive their medical services in a home or community setting. An ICF/DD-CN specializes in the unique needs of the developmentally disabled waiver participant.

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

DD/CNC, non-ventilator dependent services are limited to the following:

As stated above under “Service Definition” and continuous (24-hour) skilled nursing care and other necessary medical, nursing and developmental services as needed by the waiver participant:

a. Sufficient Registered Nurse (RN) and Licensed Vocational Nurse (LVN) staffing to allow a minimum of four (4) hours per participant per day of non-duplicated skilled nursing with a minimum of two (2) hours of the four (4) hours per participant per day being of non-duplicated RN staffing. All LVN staffing must be supervised by

an RN who is available by telephone at all times.

b. Participants residing in an ICF/DD-CN must receive 24-hour skilled nursing services provided by or under the direct supervision of an RN. An LVN can render services under the supervision of an RN when the RN is not physically present, pursuant to California Business and Professions (B&P) Code section 2859.

c. A minimum of one RN or one LVN must be in the facility and awake at all times.

d. All staff rendering direct care must maintain currently required, unrevoked licenses and/or certifications and must receive ongoing training specific to the waiver population being served.

e. The following nursing care needs are included within the scope of continuous nursing:

- Assistance with activities of daily living (ADLs) and instrumental ADLs (IADLs)
- Ventilator, tracheostomy and respiratory care
- IV therapy
- Feeding and elimination care (including tubes)
- Medication administration
- Skin care

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Intermediate Care Facility for the Developmentally Disabled – Continuous Nursing (ICF/DD-CN)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services

Provider Category:
Agency

Provider Type:
Intermediate Care Facility for the Developmentally Disabled – Continuous Nursing (ICF/DD-CN)

Provider Qualifications

License *(specify):*
Licensed as an ICF/DD-N (license is suspended in order to enroll as an ICF/DD-CN waiver provider)

Certificate *(specify):*
Enrolled in the Medi-Cal program as an ICF/DD-CN
NF/AH Waiver Standards of Participation (SOP)

Other Standard *(specify):*
As a NF/AH Waiver Service Provider, the ICF/DD-CN will provide a home-like setting for individuals enrolled in the NF/AH Waiver who choose an ICF/DD-CN as their place of residence. As a Waiver Service Provider, the ICF/DD-CN shall meet all applicable licensing standards and will be subject to the Waiver SOP and will adhere to the documentation, training, and quality assurance requirements identified in the approved waiver.

An ICF/DD-CN is a residential facility with a non-institutional, homelike environment and provides inpatient care that includes the following array of services: medical supervision, 24-hour skilled nursing services and supportive care including pharmacy, dietary, social, recreational and other services for waiver participants who meet the medical level of care criteria of the NF/AH waiver and are persons whose medical condition(s) are within the scope of practice for an ICF/DD-CN as follows: persons who are developmentally disabled with physical and mental disabilities that preclude independent living and self-care. Such persons may be diagnosed with a terminal illness or a life-threatening illness or may be catastrophically and severely disabled. The primary need of ICF/DD-CN residents shall be the availability of skilled nursing care on a continuous basis.

1. Legal Authority and Requirements

An ICF/DD-CN shall be licensed as an ICF/DD-N in accordance with Health and Safety (H&S) Code sections 1250(e) and (h), 1265 et.al., 1266 et.al. and1268.6; and California Code of Regulations (CCR), Title 22, Division 5, Chapter 8, Article 2; and shall provide skilled nursing waiver services in accordance with the CCR, Title 22 sections 51003 and 51344 and the approved waiver document.

An ICF/DD-CN must be enrolled as a Medi-Cal Waiver provider and shall meet the standards specified in H&S Code section 1250(m), the CCR, Title 22 sections 51200(a) and 51003.30 through 51000.55. Any subsequent adopted laws or regulations that exceed the ICF/DD-CN waiver provider participant requirements shall supersede the specified CCR sections and shall be applicable to all ICF/DD-CN providers.

2. Physical Plant and Health and Safety Requirements

To ensure the health and safety of the Waiver participate the physical plant of the ICF/DD-CN shall conform to the CCR, Title 22, Division 5, Chapter 8, Article 5, as described in part in the following:

a. Must meet all requirements of the federal ICF/MR Conditions of Participation, Physical Environment [42 CFR section 483.470(a)(1) through (k)(2)].

b. Each ICF/DD-CN must submit an initial emergency plan for evacuation and sheltering in place, no later than 30 days following the signing of the provider agreement. The emergency plan will be reviewed, revised as necessary and be submitted annually to the California Department of Public Health (CDPH) coordinator for review and approval.

- The plan will include detailed written plans and procedures to meet all potential emergencies and disasters [42 CFR sections 483.75(m) and 483.470(h); H&S Code section 1336.3(b); CCR, Title 22 section 73929(a) and (b)].

- The provider's "External Disaster Plan" should address those types of emergencies relevant to the residence and its geographical location; the needs of the individuals served; and the highest risks for the residence's area. The plan must consider all of the following: transportation needs, sources of emergency utilities and supplies, procedures for assigning and recalling staff, procedures for moving participants from damaged areas of the residence, provisions for the conversion of useable space, procedure for emergency transfers of patients, evacuation routes, emergency phone numbers of physicians, health facilities and local fire and EMT personnel, procedures for maintaining a record of participant movement and the method of sending all pertinent personal and medial information with them, security of the residence, procedures for the emergency discharge of participants, and provisions for prompt medical assessment and treatment of participants and staff as needed.

- Each provider is encouraged to consult with local emergency planning officials to ensure that their plan does not conflict with the city and/or county plans.

c. 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.

d. The ICF/DD-CN shall be maintained as homelike, residential setting with sufficient space to allow for the comfort and privacy of each resident and adequate space for the staff to complete their tasks.

e. 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.

f. Residents' 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.

g. 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.

h. 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. An ICF/DD-CN Providing Waiver Services

An ICF/DD-CN shall employ a variety of providers and render services as indicated below. The individuals providing waiver services to participants shall meet all licensing requirements as specified in the B&P Code and the SOPs of the NF/AH Waiver. The primary services provided by an ICF/DD-CN are continuous skilled nursing care and developmental disability services and support, which must be available to participants on a 24-hour, 7-days per week basis.

4. Nursing Services

- Sufficient Register Nurse (RN) and Licensed Vocational Nurse (LVN) staffing to allow a minimum of four (4) hours per participant per day of non-duplicated skilled nursing with a minimum of two (2) hours of the four (4) hours being non-duplicated RN staffing. All LVN staffing must be supervised by an RN who is available by telephone at all time.

- Participants residing in an ICF/DD-CN residence must have available 24-hour skilled nursing services provided by or under the direct supervision of an RN. An LVN may render services under the supervision of an RN when the RN is not physically present, within his/her scope of practice (B&P Code section 2725).

- A minimum of one RN and one LVN in the facility and awake at all time.

- All staff rendering direct care must maintain currently required, unrevoked licenses and/or certifications and must receive ongoing training specific to the waiver population being served.

- Skilled nursing care includes, but is not limited to all of the following:
  - Assistance with ADLs and IADLs
  - Ventilator, tracheostomy and respiratory care
  - IV therapy
  - Feeding and elimination care (including tubes)
  - Medication administration
  - Skin care

5. Other Health Related Services

a. In addition to skilled nursing services, an ICF/DD-CN shall provide or arrange for the following basic services, as described on a participant's care plan, to be provided to individuals enrolled in the waiver, as part of the per diem rate paid to ICF/DD-CN Waiver providers:

- Medical supervision
- Pharmacy consultation
- Dietary consultation
- Social services

- Recreational services
- Transportation to and from necessary medical appointments
- Housekeeping and laundry services
- Cooking and shopping
- Any developmentally disabled-related services as specified in the participant's service plan.

b. Each waiver participant 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 individual at the request of the individual. The ICF/DD-CN will establish a plan of treatment (POT) (see Appendix D-1 for service plan information) 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 IDCF/DD-CN's per diem rate under this waiver. The ICF/DD-CN will be responsible for arranging for such services, including counseling, physical, occupational or speech therapy, education and training for the waiver participant and/or caregivers, assessment for and repair of durable medical equipment and off-site personal care services.

6. Documentation

a. All Waiver services rendered by the ICF/DD-CN shall require authorization and reauthorization in accordance with the CCR, Title 22 section 51003.

b. A Treatment Authorization Request (TAR) shall be prepared by the ICF/DD-CN and submitted to In-Home Operations (IHO) for each waiver participant residing in the facility. The initial TAR shall be accompanied by an RN-developed assessment of care needs, home safety evaluation and a POT signed by a primary care physician (see Appendix D-1 for details regarding the participant service plan). The initial TAR shall also 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.

c. Each ICF/DD-CN shall maintain a medical record chart for each waiver participant in residence. This medical record shall include documentation regarding all participant contact made with facility professional personnel, current POTs, referral requests and outcomes of said referrals and shall be available to appropriate IHO staff for any scheduled or unscheduled visit. All facility 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 facility for three years.

The ICF/DD-CN shall also maintain records to document that all requirements specified in this waiver have been met, including those requirements related to staffing of the facility.

7. Quality Control/Quality Assurance

Quality control/quality assurance reviews will be in accordance with the Long-Term Care Division/IHO's Quality Assurance Plan, as described in the approved waiver.

8. Training Requirements

As an enrolled NF/AH Waiver provider, the ICF/DD-CN shall ensure all facility staff receive training regarding services appropriate for each waiver participant based upon the participant's care needs. Appropriate in-house supervisors shall arrange for the training of their staff to be provided by the ICF/DD-CN. Provision of this training is a requirement to be enrolled as a waiver provider and is not separately reimbursed by either Medi-Cal or the waiver.

Such training shall be conducted on a quarterly basis and shall be documented, including the information taught, attendees, and the qualifications of the instructor. The ICF/DD-CN is also responsible for providing appropriate orientation for all new facility employees.

CDPH's Licensing and Certification Division will be responsible for determining if the policies and procedures for training of ICF/DD-CN staff are adequate to ensure the appropriate care of residents and to ensure their health and safety.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health, Licensing and Certification Division
Frequency of Verification:
Bi-annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services
Service Definition *(Scope):*
DD/CNC, Ventilator Dependent Services are provided to waiver participants who require 24-hour personal care, developmental services, and nursing supervision, are ventilator dependent and are developmentally disabled. Waiver participants must be certified by a physician as requiring continuous skilled nursing care. Waiver participants who are non-ventilator dependent may not receive DD/CNC, Ventilator Dependent Services.

Such individuals have chosen to reside in an ICF/DD-CN and services must be available to waiver participants 24 hours a day, 7 days a week. NF/AH participants who choose to receive waiver services in a setting other than an ICF/DD-CN may not receive DD/CNC, ventilator dependent services.

ICF/DD-CN residential facilities have non-institutional, homelike environments and are an alternative setting for developmentally disabled individuals that require an institutional level of care but choose to receive their medical services in a home or community setting. The ICF/DD-CN specializes in the unique needs of the developmentally disabled waiver participant.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
DD/CNC, ventilator dependent services are limited to the following:
As stated above under “Service Definition” and continuous (24-hour) skilled nursing care and other necessary medical, nursing and developmental services as needed by the waiver participant:

a. Sufficient Registered Nurse (RN) and Licensed Vocational Nurse (LVN) staffing to allow a minimum of four (4) hours per participant per day of non-duplicated skilled nursing with a minimum of two (2) hours of the four (4) hours per participant per day being of non-duplicated RN staffing. All LVN staffing must be supervised by an RN who is available by telephone at all times.

b. Participants residing in an ICF/DD-CN must receive 24-hour skilled nursing services provided by or under the direct supervision of an RN. An LVN can render services under the supervision of an RN when the RN is not physically present, pursuant to California Business and Professions (B&P) Code section 2859.

c. A minimum of one RN or one LVN must be in the facility and awake at all times.

d. All staff rendering direct care must maintain currently required, unrevoked licenses and/or certifications and must receive ongoing training specific to the waiver population being served.

e. The following nursing care needs are included within the scope of continuous nursing:
- Assistance with activities of daily living (ADLs) and instrumental ADLs (IADLs)
- Ventilator, tracheostomy and respiratory care
- IV therapy
- Feeding and elimination care (including tubes)
- Medication administration
- Skin care

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Intermediate Care Facility for the Developmentally Disabled – Continuous Nursing (ICF/DD-CN)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services

Provider Category:
Agency
Provider Type:
Intermediate Care Facility for the Developmentally Disabled – Continuous Nursing (ICF/DD-CN)
Provider Qualifications
License *(specify):*
Licensed as an ICF/DD-N (license is suspended in order to enroll as an ICF/DD-CN waiver provider)
Certificate *(specify):*
Enrolled in the Medi-Cal program as an ICF/DD-CN
NF/AH Waiver Standards of Participation (SOP)
Other Standard *(specify):*
As a NF/AH Waiver Service Provider, the ICF/DD-CN will provide a home-like setting for individuals enrolled in the NF/AH Waiver who choose an ICF/DD-CN as their place of residence. As a Waiver Service Provider, the ICF/DD-CN shall meet all applicable licensing standards and will be subject to the Waiver SOP and will adhere to the documentation, training, and quality assurance requirements identified in the approved waiver.

An ICF/DD-CN is a residential facility with a non-institutional, homelike environment and provides inpatient care that includes the following array of services: medical supervision, 24-hour skilled nursing services and supportive care including pharmacy, dietary, social, recreational and other services for waiver participants who meet the medical level of care criteria of the NF/AH waiver and are persons whose medical condition(s) are within the scope of practice for an ICF/DD-CN as follows: persons who are developmentally disabled with physical and mental disabilities that preclude independent living and self-care. Such persons may be diagnosed with a terminal illness or a life-threatening illness or may be catastrophically and severely disabled. The primary need of ICF/DD-CN residents shall be the availability of skilled nursing care on a continuous basis.

1. Legal Authority and Requirements

An ICF/DD-CN shall be licensed as an ICF/DD-N in accordance with Health and Safety (H&S) Code sections 1250(e) and (h), 1265 et.al., 1266 et.al. and1268.6; and California Code of Regulations (CCR), Title 22, Division 5, Chapter 8, Article 2; and shall provide skilled nursing waiver services in accordance with the CCR, Title 22 sections 51003 and 51344 and the approved waiver document.

An ICF/DD-CN must be enrolled as a Medi-Cal Waiver provider and shall meet the standards specified in H&S Code section 1250(m), the CCR, Title 22 sections 51200(a) and 51003.30 through 51000.55. Any subsequent adopted laws or regulations that exceed the ICF/DD-CN waiver provider participant requirements shall supersede the specified CCR sections and shall be applicable to all ICF/DD-CN providers.

2. Physical Plant and Health and Safety Requirements

To ensure the health and safety of the Waiver participate the physical plant of the ICF/DD-CN shall conform to the CCR, Title 22, Division 5, Chapter 8, Article 5, as described in part in the following:

a. Must meet all requirements of the federal ICF/MR Conditions of Participation, Physical Environment [42 CFR section 483.470(a)(1) through (k)(2)].

b. Each ICF/DD-CN must submit an initial emergency plan for evacuation and sheltering in place, no later than 30 days following the signing of the provider agreement. The emergency plan will be reviewed, revised as necessary and be submitted annually to the California Department of Public Health (CDPH) coordinator for review and approval.

• The plan will include detailed written plans and procedures to meet all potential emergencies and disasters [42 CFR sections 483.75(m) and 483.470(h); H&S Code section 1336.3(b); CCR, Title 22 section 73929(a) and (b)].

• The provider's "External Disaster Plan" should address those types of emergencies relevant to the residence and its geographical location; the needs of the individuals served; and the highest risks for the residence's area. The plan must consider all of the following: transportation needs, sources of emergency utilities and supplies, procedures for assigning and recalling staff, procedures for moving participants from damaged areas of the residence, provisions for the conversion of useable space, procedure for emergency transfers of patients, evacuation routes, emergency phone numbers of physicians, health facilities and local fire and EMT personnel, procedures for maintaining a record of participant movement and the method of sending all pertinent personal and medial information with them, security of the residence, procedures for the emergency discharge of participants, and provisions for prompt medical assessment and treatment of participants and staff as needed.

• Each provider is encouraged to consult with local emergency planning officials to ensure that their plan does not conflict with the city and/or county plans.

c. 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.

d. The ICF/DD-CN shall be maintained as homelike, residential setting with sufficient space to allow for the comfort and privacy of each resident and adequate space for the staff to complete their tasks.

e. 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.

f. Residents' 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.

g. 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.

h. 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. An ICF/DD-CN Providing Waiver Services

An ICF/DD-CN shall employ a variety of providers and render services as indicated below. The individuals providing waiver services to participants shall meet all licensing requirements as specified in the B&P Code and the SOPs of the NF/AH Waiver. The primary services provided by an ICF/DD-CN are continuous skilled nursing care and developmental disability services and support, which must be available to participants on a 24-hour, 7-days per week basis.

4. Nursing Services

• Sufficient Register Nurse (RN) and Licensed Vocational Nurse (LVN) staffing to allow a minimum of four (4) hours per participant per day of non-duplicated skilled nursing with a minimum of two (2) hours of the four (4) hours being non-duplicated RN staffing. All LVN staffing must be supervised by an RN who is available by telephone at all time.

• Participants residing in an ICF/DD-CN residence must have available 24-hour skilled nursing services provided by or under the direct supervision of an RN. An LVN may render services under the supervision of an RN when the RN is not physically present, within his/her scope of practice (B&P Code section 2725).

• A minimum of one RN and one LVN in the facility and awake at all time.

• All staff rendering direct care must maintain currently required, unrevoked licenses and/or certifications and must receive ongoing training specific to the waiver population being served.

• Skilled nursing care includes, but is not limited to all of the following:
  • Assistance with ADLs and IADLs
  • Ventilator, tracheostomy and respiratory care
  • IV therapy
  • Feeding and elimination care (including tubes)
  • Medication administration
  • Skin care

5. Other Health Related Services

a. In addition to skilled nursing services, an ICF/DD-CN shall provide or arrange for the following basic services, as described on a participant's care plan, to be provided to individuals enrolled in the waiver, as part of the per diem rate paid to ICF/DD-CN Waiver providers:

• Medical supervision
• Pharmacy consultation
• Dietary consultation
• Social services
• Recreational services
• Transportation to and from necessary medical appointments
• Housekeeping and laundry services
• Cooking and shopping
• Any developmentally disabled-related services as specified in the participant’s service plan.

b. Each waiver participant 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 individual at the request of the individual. The ICF/DD-CN will establish a plan of treatment (POT) (see Appendix D-1 for service plan information) 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 IDCF/DD-CN’s per diem rate under this waiver. The ICF/DD-CN will be responsible for arranging for such services, including counseling, physical, occupational or speech therapy, education and training for the waiver participant and/or caregivers, assessment for and repair of durable medical equipment and off-site personal care services.

6. Documentation

a. All Waiver services rendered by the ICF/DD-CN shall require authorization and reauthorization in

accordance with the CCR, Title 22 section 51003.

b. A Treatment Authorization Request (TAR) shall be prepared by the ICF/DD-CN and submitted to In-Home Operations (IHO) for each waiver participant residing in the facility. The initial TAR shall be accompanied by an RN-developed assessment of care needs, home safety evaluation and a POT signed by a primary care physician (see Appendix D-1 for details regarding the participant service plan). The initial TAR shall also 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.

c. Each ICF/DD-CN shall maintain a medical record chart for each waiver participant in residence. This medical record shall include documentation regarding all participant contact made with facility professional personnel, current POTs, referral requests and outcomes of said referrals and shall be available to appropriate IHO staff for any scheduled or unscheduled visit. All facility 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 facility for three years.

The ICF/DD-CN shall also maintain records to document that all requirements specified in this waiver have been met, including those requirements related to staffing of the facility.

7. Quality Control/Quality Assurance

Quality control/quality assurance reviews will be in accordance with the Long-Term Care Division/IHO's Quality Assurance Plan, as described in the approved waiver.

8. Training Requirements

As an enrolled NF/AH Waiver provider, the ICF/DD-CN shall ensure all facility staff receive training regarding services appropriate for each waiver participant based upon the participant's care needs. Appropriate in-house supervisors shall arrange for the training of their staff to be provided by the ICF/DD-CN. Provision of this training is a requirement to be enrolled as a waiver provider and is not separately reimbursed by either Medi-Cal or the waiver.

Such training shall be conducted on a quarterly basis and shall be documented, including the information taught, attendees, and the qualifications of the instructor. The ICF/DD-CN is also responsible for providing appropriate orientation for all new facility employees.

CDPH's Licensing and Certification Division will be responsible for determining if the policies and procedures for training of ICF/DD-CN staff are adequate to ensure the appropriate care of residents and to ensure their health and safety.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health, Licensing and Cerification Division

Frequency of Verification:

Bi-annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations

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 DHCS 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 waiver provider should include the following:

1. Primary care physician'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:

• 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;
• 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
• A description of similar equipment used either 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 DHCS NE will adjudicate the TAR after all requested documentation has been received and reviewed, the provider overseeing the administration of the service submits all of the medical documentation and invoices for authorization and reimbursement 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 DHCS 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's 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:

The recipient's place of residence changes or 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.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	HCBS Benefit Provider – Licensed Clinical Social Worker (LCSW)
Individual	HCBS Benefit Provider – Marriage and Family Therapist (MFT)
Individual	HCBS Benefit Provider – Licensed Psychologist
Agency	Professional Corporation
Agency	Non-Profit Agency
Agency	Home Health Agency (HHA) – Registered Nurse (RN)
Individual	HCBS Waiver Nurse Provider – Registered Nurse (RN)
Agency	Durable Medical Equipment (DME) Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual

Provider Type:
HCBS Benefit Provider – Licensed Clinical Social Worker (LCSW)

Provider Qualifications

License *(specify):*
BPC §§4990-4998.7
Title 16, §§1870-1881

Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the NF/AH Waiver the role of a LCSW as a NF/AH 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 NF/AH 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 DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Board of Behavioral Sciences
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual
Provider Type:
HCBS Benefit Provider – Marriage and Family Therapist (MFT)
Provider Qualifications

License *(specify):*
BPCBPC §§4980-4989
Title 16, §§1829-1848
Certificate *(specify):*

Other Standard *(specify):*
A Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a MFT. Under the NF/AH Waiver, the role of a MFT as a NF/AH 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 NF/AH 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 DHCS/IHO.

4. Provide case management services consistent with the primary care physician's orders and the POT as authorized by DHCS/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.

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.

Verification of Provider Qualifications
Entity Responsible for Verification:
California Board of Behavioral Sciences
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:
HCBS Benefit Provider – Licensed Psychologist
Provider Qualifications

License *(specify):*
BPC §§2909 et seq.
Title 16, §§1380 et seq.
Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the NF/AH Waiver, the role of a Licensed Psychologist as a 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 NF/AH 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 DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Board of Psychology
Frequency of Verification:
Biennially

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Professional Corporation
Provider Qualifications
License *(specify):*
CC §13401(b)
Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide services authorized under the NF/AH Waiver and is enrolled as an HCBS Waiver Professional Corporation provider, and meets and maintains the SOP minimal qualifications for a Professional Corporation. Under the HCBS NF/AH Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:

• Case Management/Coordination (CM/C)
• 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 NF/AH 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 NF/AH 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 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 DHCS/IHO. The professional corporation must notify DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business license, appropriate for the services purchased

Certificate *(specify):*

Other Standard *(specify):*
Non-Profit Agency
A Non-Profit Agency/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 NF/AH Waiver SOP and Medi-Cal Provider requirements may provide NF/AH Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following NF/AH 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)
• Home Respite
• Waiver Personal Care Services (WPCS)

Minimum qualifications for a Non-Profit Organization functioning as an NF/AH 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, or have at least 5 years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

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 NF/AH Waiver services and at least annually reviews the NF/AH Waiver services requirements. Training of NF/AH Waiver service providers must be specific to the conditions and care of NF/AH 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 NF/AH 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 employs 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.
b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM/C, 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 DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/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 DHCS/IHO.

10. Employs qualified professional providers to provide NF/AH Waiver CM/C, CTS, HS, EAA, PERS, TCM 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, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM 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 professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation, which may include activities commonly described as peer mentoring, or WPCS, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing 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, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have a 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, or

c. Have one year experience as a Peer Mentor/Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or 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 DHCS/IHO.

12. The Non-Profit Organization must provide Case Management/Coordination services consistent with the participant's choice and interests, the primary care physician's orders and the NF/AH 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 NF/AH Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest and the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interest and medical care needs are addressed. The POT will identify all the choices and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and
b. Facilitate the process of collaboration and assessment with 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/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current

choices, interests and 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 participant and primary care physician no less frequently than once every six months.
c. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Attorney General's registry of Charitable Trusts
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Home Health Agency (HHA) – Registered Nurse (RN)
Provider Qualifications

License *(specify):*
HHA Title 22, §§74659 et seq.
RN BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DPH Licensing and Certification
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual
Provider Type:
HCBS Waiver Nurse Provider – Registered Nurse (RN)
Provider Qualifications

License *(specify):*
BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4

Certificate *(specify):*

Other Standard *(specify):*
Under the HCBS NF/AH Waiver, the role of the NF/AH Waiver Registered Nurse (RN) provider is to provide:
• Case Management
• Community Transition Service
• Environmental Adaptations
• Family Training
• Habilitation Services
• Medical Equipment Operating Expenses
• Private Duty Nursing
• Respite Care
• Transitional Case Management
1.Definitions:
a. "NF/AH Waiver Nurse Provider" means a Registered Nurse who provides NF/AH Waiver RN services, as defined in subsection b. 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.

To ensure the health, safety, and well-being of the vulnerable NF/AH Waiver population, a NF/AH Waiver Nurse Provider application will not be processed should it be determined through official documentation that the professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal,California or another State's licensing agency; or has been subject to any disciplinary action or currently in or pending an investigation for the following types of complaints:
• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual,violent,or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

A NF/AH Waiver RN 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. IHO may require additional documentation to support requests of this nature. Documentation required before IHO can authorize such a request, is a written explanation of the attempts made to enlist and retain an NF/AH 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. "NF/AH Waiver RN services" means private duty nursing services, as described the in NF/AH Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an NF/AH Waiver RN, as defined in subsection a. above and c. below, 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, 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 DHCS.

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 DHCS/IHO as indicated.

Requirements of the NF/AH 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, unencumbered 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 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 DHCS/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 DHCS/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. This should include a diagram of the participant's home.

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 begins receiving services.

vii. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's 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 unencumbered RN licensure prior to expiration.

ii. Written evidence, in a format acceptable to DHCS/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 DHCS/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 primary care physician orders.

iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated 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 NF/AH Waiver LVN who is a Licensed Vocational Nurse (LVN):

a. The initial TAR shall be accompanied by all of the following documentation:

i. Current, unencumbered license to practice as an RN in the State of California.

ii. Current BLS certification.

iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, as specified in section B, subsection 1(a)(iii) "requirements of the NF/AH Waiver LVN", above.

iv. Written evidence, in a format acceptable to DHCS/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 NF/AH Waiver LVN", above.

vi. Written summary, in a format acceptable to DHCS/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 unencumbered RN licensing prior to expiration.

ii. Written summary, in a format acceptable to DHCS/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 NF/AH Waiver RN", above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the NF/AH Waiver RN", above.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Board of Registered Nursing
Frequency of Verification:
Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Durable Medical Equipment (DME) Provider
Provider Qualifications

License *(specify):*
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)
Certificate *(specify):*

Other Standard *(specify):*
Business license appropriate for the services purchased.

Verification of Provider Qualifications

Entity Responsible for Verification:
CDPH, Food and Drug Branch
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Facility Respite
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:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home and Community-Based Continuous Care Facility (HCBCCF) [Congregate Living Health Facility (CLHF)]

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Facility Respite

Provider Category:
Agency

Provider Type:
Home and Community-Based Continuous Care Facility (HCBCCF) [Congregate Living Health Facility (CLHF)]

Provider Qualifications

License *(specify):*
HSC §§1250et seq.
Title 22, §§51246 et seq.

Certificate *(specify):*

Other Standard *(specify):*
NF/AH Waiver Standards of Participation
As a NF/AH Waiver Service Provider, the HCBCCF operating as a CLHF will provide a home like setting for individuals enrolled in the NF/AH Waiver who chooses a CLHF as their place of residence. As a Waiver Service Provider, the CLHF shall meet all applicable licensing standards and will be subject to the Waiver SOP and will adhere to the documentation, training, and quality assurance requirements identified in the approved waiver.
As a Medi-Cal 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 a CLHF 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

A CLHF 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.

A CLHF 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 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. A CLHF Providing Waiver Services

As a provider of Waiver services, a CLHF shall employ a variety of providers and render services as indicated below. The individuals providing waiver services to Waiver participants shall meet all licensing requirements as specified in California Business and Professions Code and all the SOP of the NF/AH Waiver. The primary category of service provided by a CLHF is nursing services, which must be available to 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), a CLHF 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 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, a CLHF will provide or arrange for the following basic services to be provided to individuals enrolled in the 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 Waiver service provider, each NF/AH 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 CLHF's 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 Waiver participant 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 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 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 IHO for each waiver participant residing in a CLHF that renders Waiver services. The initial TAR for each waiver participant shall be accompanied by a RN developed assessment of care needs, home safety evaluation, and a 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.
c. Each CLHF 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 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 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 Long-Term Care

Division/In-Home Operation's Quality Assurance Plan, as described in the approved waiver.
8. Training Requirements
As a licensed CLHF 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 Waiver provider and is not reimbursed by either Medi-Cal or the Waiver.

Pursuant to the Policies and Procedures of the CLHF and as a 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. DHCS Licensing & Certification (L&C) 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 L&C, 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.

Verification of Provider Qualifications

Entity Responsible for Verification:
DPH Licensing and Certification
Frequency of Verification:
Biennially

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Family/Caregiver Training
Service Definition *(Scope):*
Family/Caregiver Training services are training and counseling for families and/or unlicensed caregivers of waiver participants. Training for family members includes instruction about medical treatment, use of durable medical equipment, how to provide medical care services and specialized dietary plans for the participant in the absence of the paid care providers. All family training must be included in the participant's primary care physician signed POT.

Unlicensed caregivers should be evaluated to determine specific training needs that will meet the participant's unique needs and the services to be provided. It should also assist the family, participant, and/or circle of support in ensuring the unlicensed caregiver has the necessary skills, competencies and qualifications to provide those services. All unlicensed caregiver training must be included in the participant's primary care physician signed POT.

Family/Caregiver Training services in the participant's home may be provided only by a Registered Nurse. To render Family/Caregiver Training the provider must document the training that is needed and the process to meet the need, and submit the documentation with a request for training to the DHCS RN. The DHCS RN will review the documentation and authorize the service when medically necessary to ensure the health and safety of

the waiver participant. Upon completion of the training, the provider will submit documentation of the training results to the DHCS RN.

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

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency (HHA) – Registered Nurse (RN)
Individual	HCBS Waiver Nurse Provider – Registered Nurse (RN)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family/Caregiver Training

Provider Category:
Agency

Provider Type:
Home Health Agency (HHA) – Registered Nurse (RN)

Provider Qualifications

License *(specify):*
HHA Title 22, §§74659 et seq.
RN BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DPH Licensing and Certification

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family/Caregiver Training

Provider Category:
Individual
Provider Type:
HCBS Waiver Nurse Provider – Registered Nurse (RN)
Provider Qualifications

License *(specify):*
BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4
Certificate *(specify):*

Other Standard *(specify):*
Under the HCBS NF/AH Waiver, the role of the NF/AH Waiver Registered Nurse (RN) provider is to provide:
• Case Management
• Community Transition Service
• Environmental Adaptations
• Family Training
• Habilitation Services
• Medical Equipment Operating Expenses
• Private Duty Nursing
• Respite Care
• Transitional Case Management
1.Definitions:
a. "NF/AH Waiver Nurse Provider" means a Registered Nurse who provides NF/AH Waiver RN services, as defined in subsection b. 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.

To ensure the health, safety, and well-being of the vulnerable NF/AH Waiver population, a NF/AH Waiver Nurse Provider application will not be processed should it be determined through official documentation that the professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal,California or another State's licensing agency; or has been subject to any disciplinary action or currently in or pending an investigation for the following types of complaints:
• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual,violent,or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

A NF/AH Waiver RN 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. IHO may require additional documentation to support requests of this nature. Documentation required before IHO can authorize such a request, is a written explanation of the attempts made to enlist and retain an NF/AH 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. "NF/AH Waiver RN services" means private duty nursing services, as described the in NF/AH Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an NF/AH Waiver RN, as defined in subsection a. above and c. below, 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, 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 DHCS.

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 DHCS/IHO as indicated.

Requirements of the NF/AH 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, unencumbered 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 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 DHCS/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 DHCS/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. This should include a diagram of the participant's home.

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 begins receiving services.

vii. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's 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 unencumbered RN licensure prior to expiration.

ii. Written evidence, in a format acceptable to DHCS/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 DHCS/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 primary care physician orders.

iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated 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 NF/AH Waiver LVN who is a Licensed Vocational Nurse (LVN):

a. The initial TAR shall be accompanied by all of the following documentation:

i. Current, unencumbered license to practice as an RN in the State of California.

ii. Current BLS certification.

iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, as specified in section B, subsection 1(a)(iii) "requirements of the NF/AH Waiver LVN", above.

iv. Written evidence, in a format acceptable to DHCS/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 NF/AH Waiver LVN", above.

vi. Written summary, in a format acceptable to DHCS/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 unencumbered RN licensing prior to expiration.

ii. Written summary, in a format acceptable to DHCS/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 NF/AH Waiver RN", above.

iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the NF/AH Waiver RN", above.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing

Frequency of Verification:

Biennially

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Medical Equipment Operating Expense

Service Definition *(Scope):*

Medical Equipment Operating Expenses are services necessary to prevent re-institutionalization 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, DHCS/IHO will evaluate the request for this service and may grant exceptions to this definition.

A waiver service provider may submit a request for the authorization of this service to DHCS/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/coordinator is responsible for notifying the local utility providers that the NF/AH 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 DHCS NE.

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

The minimum monthly claim for Medical Equipment Operating Expense is $20.00, the maximum is $75.00.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	HCBS Benefit Provider – Licensed Clinical Social Worker (LCSW)
Individual	HCBS Waiver Nurse Provider – Registered Nurse (RN)
Individual	HCBS Benefit Provider – Licensed Psychologist
Individual	HCBS Benefit Provider – Marriage and Family Therapist (MFT)
Agency	Professional Corporation
Agency	Home Health Agency (HHA) – Registered Nurse (RN)
Agency	Non-Profit Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

Provider Category:
Individual

Provider Type:
HCBS Benefit Provider – Licensed Clinical Social Worker (LCSW)

Provider Qualifications

License *(specify):*
BPC §§4990-4998.7
Title 16, §§1870-1881

Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the NF/AH Waiver the role of a LCSW as a NF/AH 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 NF/AH 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 DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Board of Behavioral Sciences
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

Provider Category:
Individual
Provider Type:
HCBS Waiver Nurse Provider – Registered Nurse (RN)
Provider Qualifications

License *(specify):*
BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4
Certificate *(specify):*

Other Standard *(specify):*
Under the HCBS NF/AH Waiver, the role of the NF/AH Waiver Registered Nurse (RN) provider is to provide:
• Case Management
• Community Transition Service
• Environmental Adaptations

• Family Training
• Habilitation Services
• Medical Equipment Operating Expenses
• Private Duty Nursing
• Respite Care
• Transitional Case Management
1.Definitions:
a. “NF/AH Waiver Nurse Provider” means a Registered Nurse who provides NF/AH Waiver RN services, as defined in subsection b. 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.

To ensure the health, safety, and well-being of the vulnerable NF/AH Waiver population, a NF/AH Waiver Nurse Provider application will not be processed should it be determined through official documentation that the professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal,California or another State’s licensing agency; or has been subject to any disciplinary action or currently in or pending an investigation for the following types of complaints:
• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual,violent,or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

A NF/AH Waiver RN 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. IHO may require additional documentation to support requests of this nature. Documentation required before IHO can authorize such a request, is a written explanation of the attempts made to enlist and retain an NF/AH 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. “NF/AH Waiver RN services” means private duty nursing services, as described the in NF/AH Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an NF/AH Waiver RN, as defined in subsection a. above and c. below, 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, 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 DHCS.

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 DHCS/IHO as indicated.

Requirements of the NF/AH 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, unencumbered 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 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 DHCS/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 DHCS/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. This should include a diagram of the participant's home.

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 begins receiving services.

vii. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's 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 unencumbered RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/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 DHCS/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 primary care physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated 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 NF/AH Waiver LVN who is a Licensed Vocational Nurse (LVN):

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current, unencumbered license to practice as an RN in the State of California.
ii. Current BLS certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, as specified in section B, subsection 1(a)(iii) "requirements of the NF/AH Waiver LVN", above.
iv. Written evidence, in a format acceptable to DHCS/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 NF/AH Waiver LVN", above.
vi. Written summary, in a format acceptable to DHCS/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 unencumbered RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/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 NF/AH Waiver RN", above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the NF/AH Waiver RN", above.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing

Frequency of Verification:
Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

Provider Category:
Individual
Provider Type:
HCBS Benefit Provider – Licensed Psychologist
Provider Qualifications
License *(specify):*
BPC §§2909 et seq.
Title 16, §§1380 et seq.
Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the NF/AH Waiver, the role of a Licensed Psychologist as a 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 NF/AH 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 DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Psychology

Frequency of Verification:

Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider – Marriage and Family Therapist (MFT)

Provider Qualifications

License *(specify):*

BPCBPC §§4980-4989
Title 16, §§1829-1848

Certificate *(specify):*

Other Standard *(specify):*

A Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a MFT. Under the NF/AH Waiver, the role of a MFT as a NF/AH 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 NF/AH 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 DHCS/IHO.

4. Provide case management services consistent with the primary care physician's orders and the POT as authorized by DHCS/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.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Board of Behavioral Sciences
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

Provider Category:
Agency
Provider Type:
Professional Corporation
Provider Qualifications

License *(specify):*
CC §13401(b)
Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide services authorized under the NF/AH Waiver and is enrolled as an HCBS Waiver Professional Corporation provider, and meets and maintains the SOP minimal qualifications for a Professional Corporation. Under the HCBS NF/AH Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:

• Case Management/Coordination (CM/C)
• 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 NF/AH 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 NF/AH 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 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 DHCS/IHO. The professional corporation must notify DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

Provider Category:
Agency
Provider Type:
Home Health Agency (HHA) – Registered Nurse (RN)
Provider Qualifications
License *(specify):*
HHA Title 22, §§74659 et seq.
RN BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DPH Licensing and Certification
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

Provider Category:
Agency
Provider Type:
Non-Profit Agency
Provider Qualifications
License *(specify):*
Business license, appropriate for the services purchased
Certificate *(specify):*

Other Standard *(specify):*
Non-Profit Agency
A Non-Profit Agency/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 NF/AH Waiver SOP and Medi-Cal Provider requirements may provide NF/AH Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following NF/AH 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)
• Home Respite
• Waiver Personal Care Services (WPCS)

Minimum qualifications for a Non-Profit Organization functioning as an NF/AH 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, or have at least 5 years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

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 NF/AH Waiver services and at least annually reviews the NF/AH Waiver services requirements. Training of NF/AH Waiver service providers must be specific to the conditions and care of NF/AH 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 NF/AH 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 employs 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.
b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM/C, 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 DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/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 DHCS/IHO.

10. Employs qualified professional providers to provide NF/AH Waiver CM/C, CTS, HS, EAA, PERS, TCM 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, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM 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 professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation, which may include activities commonly described as peer mentoring, or WPCS, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing 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, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have a 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, or

c. Have one year experience as a Peer Mentor/Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or 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 DHCS/IHO.

12. The Non-Profit Organization must provide Case Management/Coordination services consistent with the participant's choice and interests, the primary care physician's orders and the NF/AH 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 NF/AH Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest and the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interest and medical care needs are addressed. The POT will identify all the choices and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and
b. Facilitate the process of collaboration and assessment with 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/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and 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 participant and primary care physician no less frequently than once every six months.
c. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's registry of Charitable Trusts

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response (PERS) Installation and Testing

Service Definition *(Scope):*

The Personal Emergency Response System (PERS) installation and testing service is for installation and testing of a PERS for individuals who are 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 of time, and who would otherwise require routine supervision.

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

None

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	HCBS Benefit Provider – Licensed Clinical Social Worker (LCSW)
Individual	HCBS Waiver Nurse Provider – Registered Nurse (RN)
Individual	HCBS Benefit Provider – Licensed Psychologist
Individual	HCBS Benefit Provider – Marriage and Family Therapist (MFT)
Agency	Professional Corporation
Agency	Durable Medical Equipment (DME) Provider
Agency	Home Health Agency (HHA) – Registered Nurse (RN)
Agency	Non-Profit Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response (PERS) Installation and Testing

Provider Category:

Individual

Provider Type:
HCBS Benefit Provider – Licensed Clinical Social Worker (LCSW)
Provider Qualifications
License *(specify):*
BPC §§4990-4998.7
Title 16, §§1870-1881
Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the NF/AH Waiver the role of a LCSW as a NF/AH 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 NF/AH 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 DHCS/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 DHCS/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.

Verification of Provider Qualifications
Entity Responsible for Verification:
California Board of Behavioral Sciences
Frequency of Verification:
Annually

Service Type: Other Service
Service Name: Personal Emergency Response (PERS) Installation and Testing

Provider Category:
Individual
Provider Type:
HCBS Waiver Nurse Provider – Registered Nurse (RN)
Provider Qualifications
License *(specify):*
BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4
Certificate *(specify):*

Other Standard *(specify):*
Under the HCBS NF/AH Waiver, the role of the NF/AH Waiver Registered Nurse (RN) provider is to provide:
• Case Management
• Community Transition Service
• Environmental Adaptations
• Family Training
• Habilitation Services
• Medical Equipment Operating Expenses
• Private Duty Nursing
• Respite Care
• Transitional Case Management
1.Definitions:
a. "NF/AH Waiver Nurse Provider" means a Registered Nurse who provides NF/AH Waiver RN services, as defined in subsection b. 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.

To ensure the health, safety, and well-being of the vulnerable NF/AH Waiver population, a NF/AH Waiver Nurse Provider application will not be processed should it be determined through official documentation that the professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal,California or another State's licensing agency; or has been subject to any disciplinary action or currently in or pending an investigation for the following types of complaints:
• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual,violent,or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

A NF/AH Waiver RN 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. IHO may require additional documentation to support requests of this nature. Documentation required before IHO can authorize such a request, is a written explanation of the attempts made to enlist and retain an NF/AH 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. “NF/AH Waiver RN services” means private duty nursing services, as described the in NF/AH Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an NF/AH Waiver RN, as defined in subsection a. above and c. below, 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, 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 DHCS.

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 DHCS/IHO as indicated.

Requirements of the NF/AH 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, unencumbered 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 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 DHCS/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 DHCS/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. This should include a diagram of the participant's home.

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 begins receiving services.

vii. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's 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 unencumbered RN licensure prior to expiration.

ii. Written evidence, in a format acceptable to DHCS/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 DHCS/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 primary care physician orders.

iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated 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 NF/AH Waiver LVN who is a Licensed Vocational Nurse (LVN):

a. The initial TAR shall be accompanied by all of the following documentation:

i. Current, unencumbered license to practice as an RN in the State of California.

ii. Current BLS certification.

iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, as specified in section B, subsection 1(a)(iii) "requirements of the NF/AH Waiver LVN", above.

iv. Written evidence, in a format acceptable to DHCS/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 NF/AH Waiver LVN", above.

vi. Written summary, in a format acceptable to DHCS/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 unencumbered RN licensing prior to expiration.

ii. Written summary, in a format acceptable to DHCS/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 NF/AH Waiver RN", above.

iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the NF/AH Waiver RN", above.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing

Frequency of Verification:

Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Personal Emergency Response (PERS) Installation and Testing

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider – Licensed Psychologist

Provider Qualifications

License *(specify):*

BPC §§2909 et seq.

Title 16, §§1380 et seq.

Certificate *(specify):*

Other Standard *(specify):*

HCBS NF/AH Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the NF/AH Waiver, the role of a Licensed Psychologist as a 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 NF/AH 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 DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Psychology

Frequency of Verification:

Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response (PERS) Installation and Testing

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider – Marriage and Family Therapist (MFT)

Provider Qualifications

License *(specify):*

BPCBPC §§4980-4989
Title 16, §§1829-1848

Certificate *(specify):*

Other Standard *(specify):*

A Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a MFT. Under the NF/AH Waiver, the role of a MFT as a NF/AH 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 NF/AH 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 DHCS/IHO.

4. Provide case management services consistent with the primary care physician's orders and the POT as authorized by DHCS/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.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Board of Behavioral Sciences
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response (PERS) Installation and Testing

Provider Category:
Agency
Provider Type:
Professional Corporation
Provider Qualifications

License *(specify):*
CC §13401(b)
Certificate *(specify):*

Other Standard *(specify):*

A Professional Corporation is a provider that employs individuals who provide services authorized under the NF/AH Waiver and is enrolled as an HCBS Waiver Professional Corporation provider, and meets and maintains the SOP minimal qualifications for a Professional Corporation. Under the HCBS NF/AH Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:

• Case Management/Coordination (CM/C)
• 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 NF/AH 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 NF/AH 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 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 DHCS/IHO. The professional corporation must notify DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response (PERS) Installation and Testing

Provider Category:

Agency

Provider Type:

Durable Medical Equipment (DME) Provider

Provider Qualifications

License *(specify):*

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.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH, Food and Drug Branch

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response (PERS) Installation and Testing

Provider Category:
Agency
Provider Type:
Home Health Agency (HHA) – Registered Nurse (RN)
Provider Qualifications
License *(specify):*
HHA Title 22, §§74659 et seq.
RN BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DPH Licensing and Certification
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response (PERS) Installation and Testing

Provider Category:
Agency
Provider Type:
Non-Profit Agency
Provider Qualifications
License *(specify):*
Business license, appropriate for the services purchased
Certificate *(specify):*

Other Standard *(specify):*
Non-Profit Agency
A Non-Profit Agency/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 NF/AH Waiver SOP and Medi-Cal Provider requirements may provide NF/AH Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following NF/AH 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)
• Home Respite
• Waiver Personal Care Services (WPCS)

Minimum qualifications for a Non-Profit Organization functioning as an NF/AH 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, or have at least 5 years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

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 NF/AH Waiver services and at least annually reviews the NF/AH Waiver services requirements. Training of NF/AH Waiver service providers must be specific to the conditions and care of NF/AH 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 NF/AH 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 employs 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.
b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM/C, 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 DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/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 DHCS/IHO.

10. Employs qualified professional providers to provide NF/AH Waiver CM/C, CTS, HS, EAA, PERS, TCM 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, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM 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 professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation, which may include activities commonly described as peer mentoring, or WPCS, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing 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, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have a 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, or

c. Have one year experience as a Peer Mentor/Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or 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 DHCS/IHO.

12. The Non-Profit Organization must provide Case Management/Coordination services consistent with the participant's choice and interests, the primary care physician's orders and the NF/AH 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 NF/AH Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest and the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interest and medical care needs are addressed. The POT will identify all the choices and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and
b. Facilitate the process of collaboration and assessment with 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/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and 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 participant and primary care physician no less frequently than once every six months.
c. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's registry of Charitable Trusts

Frequency of Verification:

Annually

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response Systems (PERS)

Service Definition *(Scope):*

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

The PERS is connected to the participant'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 will immediately attempt 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 a waiver service provider from the DHCS NE.

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

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**

☑ **Relative**

☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	HCBS Benefit Provider – Marriage and Family Therapist (MFT)
Individual	HCBS Benefit Provider – Licensed Psychologist
Individual	HCBS Waiver Nurse Provider – Registered Nurse (RN)
Individual	HCBS Benefit Provider – Licensed Clinical Social Worker (LCSW)
Agency	Non-Profit Agency
Agency	Home Health Agency (HHA) – Registered Nurse (RN)
Agency	Durable Medical Equipment (DME) Provider
Agency	Professional Corporation

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:
Individual

Provider Type:
HCBS Benefit Provider – Marriage and Family Therapist (MFT)

Provider Qualifications

License *(specify):*
BPCBPC §§4980-4989
Title 16, §§1829-1848

Certificate *(specify):*

Other Standard *(specify):*
A Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a MFT. Under the NF/AH Waiver, the role of a MFT as a NF/AH 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 NF/AH 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 DHCS/IHO.

4. Provide case management services consistent with the primary care physician's orders and the POT as authorized by DHCS/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.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Behavioral Sciences

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider – Licensed Psychologist

Provider Qualifications

License *(specify):*

BPC §§2909 et seq.
Title 16, §§1380 et seq.

Certificate *(specify):*

Other Standard *(specify):*

HCBS NF/AH Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the NF/AH Waiver, the role of a Licensed Psychologist as a 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 NF/AH 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 DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Psychology

Frequency of Verification:

Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider – Registered Nurse (RN)

Provider Qualifications

License *(specify):*

BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4

Certificate *(specify):*

Other Standard *(specify):*

Under the HCBS NF/AH Waiver, the role of the NF/AH Waiver Registered Nurse (RN) provider is to provide:

• Case Management
• Community Transition Service
• Environmental Adaptations
• Family Training
• Habilitation Services
• Medical Equipment Operating Expenses
• Private Duty Nursing
• Respite Care
• Transitional Case Management

1.Definitions:

a. “NF/AH Waiver Nurse Provider” means a Registered Nurse who provides NF/AH Waiver RN services, as defined in subsection b. 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.

To ensure the health, safety, and well-being of the vulnerable NF/AH Waiver population, a NF/AH Waiver Nurse Provider application will not be processed should it be determined through official documentation that the professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal,California or another State’s licensing agency; or has been subject to any disciplinary action or currently in or pending an investigation for the following types of complaints:

• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual,violent,or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

A NF/AH Waiver RN 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. IHO may require additional documentation to support requests of this nature. Documentation required before IHO can authorize such a request, is a written explanation of the attempts made to enlist and retain an NF/AH 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. “NF/AH Waiver RN services” means private duty nursing services, as described the in NF/AH Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an NF/AH Waiver RN, as defined in subsection a. above and c. below, 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, 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 DHCS.

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 DHCS/IHO as indicated.

Requirements of the NF/AH 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, unencumbered 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 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 DHCS/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 DHCS/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. This should include a diagram of the participant's home.

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 begins receiving services.
vii. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's 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 unencumbered RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/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 DHCS/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 primary care physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated 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 NF/AH Waiver LVN who is a Licensed Vocational Nurse (LVN):

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current, unencumbered license to practice as an RN in the State of California.
ii. Current BLS certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, as specified in section B, subsection 1(a)(iii) "requirements of the NF/AH Waiver LVN", above.
iv. Written evidence, in a format acceptable to DHCS/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 NF/AH Waiver LVN", above.
vi. Written summary, in a format acceptable to DHCS/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 unencumbered RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/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 NF/AH Waiver RN", above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the NF/AH Waiver RN", above.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing

Frequency of Verification:

Biennially

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:
Individual
Provider Type:
HCBS Benefit Provider – Licensed Clinical Social Worker (LCSW)
Provider Qualifications
License *(specify):*
BPC §§4990-4998.7
Title 16, §§1870-1881
Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the NF/AH Waiver the role of a LCSW as a NF/AH 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 NF/AH 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 DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Behavioral Sciences

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business license, appropriate for the services purchased

Certificate *(specify):*

Other Standard *(specify):*

Non-Profit Agency

A Non-Profit Agency/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 NF/AH Waiver SOP and Medi-Cal Provider requirements may provide NF/AH Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following NF/AH 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)
• Home Respite
• Waiver Personal Care Services (WPCS)

Minimum qualifications for a Non-Profit Organization functioning as an NF/AH 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, or have at least 5 years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

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 NF/AH Waiver services and at least annually reviews the NF/AH Waiver services requirements. Training of NF/AH Waiver service providers must be specific to the conditions and care of NF/AH 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 NF/AH 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 employs 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.
b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM/C, 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 DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/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 DHCS/IHO.

10. Employs qualified professional providers to provide NF/AH Waiver CM/C, CTS, HS, EAA, PERS, TCM 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, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM 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 professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation, which may include activities commonly described as peer mentoring, or WPCS, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing 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, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have a 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, or

c. Have one year experience as a Peer Mentor/Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or 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 DHCS/IHO.

12. The Non-Profit Organization must provide Case Management/Coordination services consistent with the participant's choice and interests, the primary care physician's orders and the NF/AH 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 NF/AH Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest and the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interest and medical care needs are addressed. The POT will identify all the choices and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and
b. Facilitate the process of collaboration and assessment with 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/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and 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 participant and primary care physician no less frequently than once every six months.
c. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Attorney General's registry of Charitable Trusts
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:
Agency
Provider Type:
Home Health Agency (HHA) – Registered Nurse (RN)
Provider Qualifications

License *(specify):*
HHA Title 22, §§74659 et seq.
RN BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Agency

Provider Type:

Durable Medical Equipment (DME) Provider

Provider Qualifications

License *(specify):*

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.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

CDPH, Food and Drug Branch

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Agency

Provider Type:

Professional Corporation

Provider Qualifications

License *(specify):*

CC §13401(b)

Certificate *(specify):*

Other Standard *(specify):*

HCBS NF/AH Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide services authorized

under the NF/AH Waiver and is enrolled as an HCBS Waiver Professional Corporation provider, and meets and maintains the SOP minimal qualifications for a Professional Corporation. Under the HCBS NF/AH Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:

• Case Management/Coordination (CM/C)
• 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 NF/AH 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 NF/AH 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 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 DHCS/IHO. The professional corporation must notify DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Private Duty Nursing - Including Home Health Aide and Shared Services

Service Definition *(Scope):*

Private Duty Nursing (PDN) 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 employed by a home health agency within the scope of state law. Services are provided to a waiver participant in his/her home, home-like environment or an approved out-of-home setting.

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:

DHCS/IHO will not authorize direct care services or any combination of direct care services and protective supervision services exceeding 24 hours of care per day under this waiver regardless of funding source. Direct care services include State Plan services, such as personal care services through In-Home Supportive Services, adult or pediatric day health care, PDN, shared PDN, and/or direct care authorized by 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.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	HCBS Waiver Nurse Provider – Licensed Vocational Nurse (LVN)
Individual	HCBS Waiver Nurse Provider – Registered Nurse (RN)
Agency	Home Health Agency (HHA) – Licensed Vocational Nurse (LVN)
Agency	Home Health Agency (HHA) – Registered Nurse (RN)
Agency	Home Health Agency (HHA) – Certified Home Health Aide (CHHA)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Duty Nursing - Including Home Health Aide and Shared Services

Provider Category:
Individual
Provider Type:
HCBS Waiver Nurse Provider – Licensed Vocational Nurse (LVN)
Provider Qualifications
License *(specify):*
BPC §§2859-2873.7
Title 22, §51069;
Certificate *(specify):*

Other Standard *(specify):*
NF/AH Waiver Standards of Participation

Under the NF/AH Waiver, the role of the HCBS Waiver Nurse Provider – Licensed Vocation Nurse (LVN) is to provide:

• Private Duty Nursing (PDN)
• Respite Care

1. Definitions:
a. "HCBS Waiver Nurse Provider – Licensed Vocational Nurse (LVN)" means a LVN who provides HCBS Waiver LVN services, as defined in subsection b., 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.

To ensure the health, safety, and well-being of the vulnerable NF/AH Waiver population, a NF/AH Waiver Nurse Provider application will not be processed should it be determined through official documentation that the professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal, California or another State's licensing agency; or has been subject to any disciplinary action or currently in or pending an investigation for the following types of complaints:

• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect

• Sexual, violent, or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• LVNs on probation and have violated their probation conditions

A HCBS Waiver 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. DHCS/IHO may require additional documentation to support requests of this nature. Documentation required before DHCS/IHO can authorize such request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as 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 Waiver LVN services" means private duty nursing services, as described the in NF/AH Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an HCBS Waiver LVN, as defined in subsection a, above, and subsection c, below, 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 LVN, 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. "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.

Requirements of the HCBS Waiver LVN:

LVN acting as the direct care provider:
1. The initial TAR shall be accompanied by all of the following documentation:

a. Current unemcumbered 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 DHCS/IHO, of training or experience, as specified in section B, subsection 1(a)(iii), "requirements of the HCBS 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 DHCS/IHO, as specified in section B, subsection 1(a)(vi), "requirements of the HCBS Waiver LVN," above.

g. Medical information, as specified in section B., subsection 1(a)(vii), "requirements of the "HCBS 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 DHCS/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 DHCS/IHO and shall be required for each HCBS 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 Waiver LVN shall agree to notify DHCS/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 Waiver LVN intends to terminate HCBS, 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 DHCS/IHO.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Vocational Nursing and Psychiatric Technicians

Frequency of Verification:

Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Private Duty Nursing - Including Home Health Aide and Shared Services

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider – Registered Nurse (RN)

Provider Qualifications

License *(specify):*

BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4

Certificate *(specify):*

Other Standard *(specify):*

Under the HCBS NF/AH Waiver, the role of the NF/AH Waiver Registered Nurse (RN) provider is to provide:

• Case Management
• Community Transition Service
• Environmental Adaptations
• Family Training
• Habilitation Services
• Medical Equipment Operating Expenses
• Private Duty Nursing
• Respite Care
• Transitional Case Management

1.Definitions:

a. "NF/AH Waiver Nurse Provider" means a Registered Nurse who provides NF/AH Waiver RN services, as defined in subsection b. 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.

To ensure the health, safety, and well-being of the vulnerable NF/AH Waiver population, a NF/AH Waiver Nurse Provider application will not be processed should it be determined through official documentation that the professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal,California or another State's licensing agency; or has been subject to any disciplinary action or currently in or pending an investigation for the following types of complaints:
• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual,violent,or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

A NF/AH Waiver RN 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. IHO may require additional documentation to support requests of this nature. Documentation required before IHO can authorize such a request, is a written explanation of the attempts made to enlist and retain an NF/AH 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. "NF/AH Waiver RN services" means private duty nursing services, as described the in NF/AH Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an NF/AH Waiver RN, as defined in subsection a. above and c. below, 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, 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 DHCS.

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 DHCS/IHO as indicated.

Requirements of the NF/AH 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, unencumbered 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 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 DHCS/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 DHCS/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. This should include a diagram of the participant's home.

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 begins receiving services.
vii. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's 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 unencumbered RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/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 DHCS/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 primary care physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated 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 NF/AH Waiver LVN who is a Licensed Vocational Nurse (LVN):

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current, unencumbered license to practice as an RN in the State of California.
ii. Current BLS certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, as specified in section B, subsection 1(a)(iii) "requirements of the NF/AH Waiver LVN", above.
iv. Written evidence, in a format acceptable to DHCS/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 NF/AH Waiver LVN", above.
vi. Written summary, in a format acceptable to DHCS/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 unencumbered RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/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 NF/AH Waiver RN", above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the NF/AH Waiver RN", above.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing

Frequency of Verification:

Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Private Duty Nursing - Including Home Health Aide and Shared Services

Provider Category:
Agency
Provider Type:
Home Health Agency (HHA) – Licensed Vocational Nurse (LVN)
Provider Qualifications
License *(specify):*
HHA Title 22 §74659 et seq.
LVN BPC §§2859-2873.7
Title 22, §51069
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DPH Licensing and Certification
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Duty Nursing - Including Home Health Aide and Shared Services

Provider Category:
Agency
Provider Type:
Home Health Agency (HHA) – Registered Nurse (RN)
Provider Qualifications
License *(specify):*
HHA Title 22, §§74659 et seq.
RN BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DPH Licensing and Certification
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Private Duty Nursing - Including Home Health Aide and Shared Services

Provider Category:
Agency
Provider Type:
Home Health Agency (HHA) – Certified Home Health Aide (CHHA)
Provider Qualifications
License *(specify):*
HHA Title 22, §§74659 et seq.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DPH Licensing and Certification
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Transitional Case Management
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 Case Manager/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 a health care facility. These services will be provided before the individual's enrollment in the waiver.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	HCBS Benefit Provider – Licensed Clinical Social Worker (LCSW)
Individual	HCBS Waiver Nurse Provider – Registered Nurse (RN)
Agency	Home Health Agency (HHA) – Registered Nurse (RN)
Agency	Non-Profit Agency
Agency	Professional Corporation
Individual	HCBS Benefit Provider – Marriage and Family Therapist (MFT)
Individual	HCBS Benefit Provider – Licensed Psychologist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Case Management

Provider Category:
Individual

Provider Type:
HCBS Benefit Provider – Licensed Clinical Social Worker (LCSW)

Provider Qualifications

License *(specify):*
BPC §§4990-4998.7
Title 16, §§1870-1881

Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the NF/AH Waiver the role of a LCSW as a NF/AH 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 NF/AH 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 DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Behavioral Sciences

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Case Management

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider – Registered Nurse (RN)

Provider Qualifications

License *(specify):*

BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4

Certificate *(specify):*

Other Standard *(specify):*

Under the HCBS NF/AH Waiver, the role of the NF/AH Waiver Registered Nurse (RN) provider is to provide:

• Case Management
• Community Transition Service
• Environmental Adaptations
• Family Training
• Habilitation Services

• Medical Equipment Operating Expenses
• Private Duty Nursing
• Respite Care
• Transitional Case Management
1.Definitions:
a. “NF/AH Waiver Nurse Provider” means a Registered Nurse who provides NF/AH Waiver RN services, as defined in subsection b. 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.

To ensure the health, safety, and well-being of the vulnerable NF/AH Waiver population, a NF/AH Waiver Nurse Provider application will not be processed should it be determined through official documentation that the professional license to provide health care services has been revoked, suspended or is currently in a probationary status by a federal,California or another State’s licensing agency; or has been subject to any disciplinary action or currently in or pending an investigation for the following types of complaints:
• Drug/alcohol abuse
• Gross negligence/incompetence, resulting in patient endangerment
• Patient abuse and/or neglect
• Sexual,violent,or abusive offenses
• Fraud or theft offenses
• Mentally impaired and unsafe to practice
• Other acts or convictions substantially related to the practice of nursing
• Practicing nursing without a license
• RNs on probation and have violated their probation conditions

A NF/AH Waiver RN 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. IHO may require additional documentation to support requests of this nature. Documentation required before IHO can authorize such a request, is a written explanation of the attempts made to enlist and retain an NF/AH 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. “NF/AH Waiver RN services” means private duty nursing services, as described the in NF/AH Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an NF/AH Waiver RN, as defined in subsection a. above and c. below, 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, 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 DHCS.

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 DHCS/IHO as indicated.

Requirements of the NF/AH 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, unencumbered 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 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 DHCS/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 DHCS/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. This should include a diagram of the participant's home.

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 begins receiving services.
vii. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's 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 unencumbered RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/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 DHCS/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 primary care physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated 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 NF/AH Waiver LVN who is a Licensed Vocational Nurse (LVN):

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current, unencumbered license to practice as an RN in the State of California.
ii. Current BLS certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, as specified in section B, subsection 1(a)(iii) "requirements of the NF/AH Waiver LVN", above.
iv. Written evidence, in a format acceptable to DHCS/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 NF/AH Waiver LVN", above.
vi. Written summary, in a format acceptable to DHCS/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 unencumbered RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/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 NF/AH Waiver RN", above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the NF/AH Waiver RN", above.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing

Frequency of Verification:

Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Case Management

Provider Category:
Agency
Provider Type:
Home Health Agency (HHA) – Registered Nurse (RN)
Provider Qualifications
License *(specify):*
HHA Title 22, §§74659 et seq.
RN BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DPH Licensing and Certification
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Case Management

Provider Category:
Agency
Provider Type:
Non-Profit Agency
Provider Qualifications
License *(specify):*
Business license, appropriate for the services purchased
Certificate *(specify):*

Other Standard *(specify):*
Non-Profit Agency
A Non-Profit Agency/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 NF/AH Waiver SOP and Medi-Cal Provider requirements may provide NF/AH Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following NF/AH 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)
• Home Respite
• Waiver Personal Care Services (WPCS)

Minimum qualifications for a Non-Profit Organization functioning as an NF/AH 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, or have at least 5 years of training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree.

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 NF/AH Waiver services and at least annually reviews the NF/AH Waiver services requirements. Training of NF/AH Waiver service providers must be specific to the conditions and care of NF/AH 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 NF/AH 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 employs 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.
b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM/C, 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 DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/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 DHCS/IHO.

10. Employs qualified professional providers to provide NF/AH Waiver CM/C, CTS, HS, EAA,

PERS, TCM 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, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM 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 professionals. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation, which may include activities commonly described as peer mentoring, or WPCS, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing 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, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have a 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, or

c. Have one year experience as a Peer Mentor/Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or 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 DHCS/IHO.

12. The Non-Profit Organization must provide Case Management/Coordination services consistent with the participant's choice and interests, the primary care physician's orders and the NF/AH 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 NF/AH Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest and the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interest and medical care needs are addressed. The POT will identify all the choices and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and
b. Facilitate the process of collaboration and assessment with 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/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and 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 participant and primary care physician no less frequently than once every six months.
c. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the primary care physician's POT. Provide the participant with education and resources regarding self-advocacy and systems change.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's registry of Charitable Trusts

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Case Management

Provider Category:
Agency
Provider Type:
Professional Corporation
Provider Qualifications
License *(specify):*
CC §13401(b)
Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide services authorized under the NF/AH Waiver and is enrolled as an HCBS Waiver Professional Corporation provider, and meets and maintains the SOP minimal qualifications for a Professional Corporation. Under the HCBS NF/AH Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:

• Case Management/Coordination (CM/C)
• 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 NF/AH 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 NF/AH 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 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 DHCS/IHO. The professional corporation must notify DHCS/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 DHCS/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.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Case Management

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider – Marriage and Family Therapist (MFT)

Provider Qualifications

License *(specify):*

BPCBPC §§4980-4989
Title 16, §§1829-1848
Certificate *(specify):*

Other Standard *(specify):*
A Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a MFT. Under the NF/AH Waiver, the role of a MFT as a NF/AH 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 NF/AH 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 DHCS/IHO.

4. Provide case management services consistent with the primary care physician's orders and the POT as authorized by DHCS/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.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Board of Behavioral Sciences
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Case Management

Provider Category:

Individual

Provider Type:
HCBS Benefit Provider – Licensed Psychologist
Provider Qualifications
License *(specify):*
BPC §§2909 et seq.
Title 16, §§1380 et seq.
Certificate *(specify):*

Other Standard *(specify):*
HCBS NF/AH Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled and provides services under the NF/AH Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the NF/AH Waiver, the role of a Licensed Psychologist as a 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 NF/AH 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 DHCS/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 DHCS/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.
Verification of Provider Qualifications
Entity Responsible for Verification:
California Board of Psychology
Frequency of Verification:
Biennially

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *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:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

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):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **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):

Anyone providing direct care to waiver participants in a ICF/DD-CN residence is subject to a criminal history and background check conducted by CDPH. All staff must be cleared prior to initiating contact with participants.

The providers must self-attest the verification of nursing licensure by the state Board of Registered Nurses (BRN). This action will include a review of any pending disciplinary action against potential staff.

The ICF/DD-CN residence RN staff must be licensed by the BRN. A criminal history and background check is required by the BRN in order to be issued a California RN license.

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):

- ◉ **No. The State does not conduct abuse registry screening.**
- ○ **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):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

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

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **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).**

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

Facility Type	
Intermediate Care Facility for the Developmentally Disabled - Continuous Nursing	
Home and Community-Based Continuous Care Facility - Congregate Living Health Facility (CLHF)	

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.

The Congregate Living Health Facilities (CLHF) enrolled as a Home and Community-Based Continuous Care Facility waiver provider has between 6 and 12 beds with most having 6 or less. As a waiver provider these facilities are regarded as the least restrictive alternative home-like setting for certain individuals whose primary need is the availability of skilled nursing care on a recurring, intermittent, extended, or continuous basis and whose medical needs require institutional level of care but who choose to receive their medical services in a home or community setting instead of a skilled nursing facility. Waiver participants residing in this type of facility are regarded as living in their own home, albeit a licensed facility. CLHFs must comply with state landlord and tenant and eviction laws and all local ordinances that apply to other similar residences. CLHF residents have the full array of individual rights and are encouraged to exercise his/her rights.

The Home and Community-Based Continuous Care Facility CLHFs are single family homes situated in residential neighborhoods providing a homelike setting that has private or semi-private bedrooms and access to kitchens and walk/roll in bathrooms.

A CLHF provides sufficient space to allow for the comfort and privacy of each resident and adequate space for the individual to visit with family or friends as well as for staff to complete their tasks. Common areas are used by residents for socialization and recreational activities. Residents are free to have visitors and engage in community outings as desired with the help of family, volunteers and/or staff. The waiver participant's bedrooms have sufficient space for safe storage of the resident's property, possessions, and furnishings and may be personalized and decorated to reflect the preferences of the individual. It also must permit access for the staff to complete their necessary health care functions. The number and size of bathrooms available must allow for the hygiene needs of each waiver participant and the ability of the staff to render care without spatial limitations or compromise.

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The Developmentally Disabled/Continuous Nursing Care (DD/CNC) HCBS Facilities are single family homes situated in residential neighborhoods serving no more than eight individuals at any given time. The DD/CNC specializes in serving the developmentally disabled who require extensive physical and developmental services. As a waiver provider, these facilities are regarded as the least restrictive alternative home-like setting for certain individuals whose primary need is the availability of skilled

nursing care on a continuous basis and whose medical needs require an institutional level of care but who choose to receive their medical, social and cognitive services in a home or community setting instead of an institution. Waiver participants residing in a DD/CNC are regarded as living in their own home, albeit a licensed facility. The DD/CNC must comply with state landlord and tenant and eviction laws and all local ordinances that apply to other similar residences. DD/CNC residents have the full array of individual rights and are encouraged to exercise his/her rights.

A DD/CNC provides a residential home-like setting that has private or semi-private bedrooms and access to kitchens and walk/roll in bathrooms. It provides sufficient space for the individual to visit with family or friends as well as to allow for the comfort and privacy of each resident and adequate space for the staff to complete their tasks. Common areas are used by residents for socialization and recreational activities and residents are free to have visitors and engage in community outings as desired with the help of family, volunteers and/or staff. The waiver participant's bedrooms have sufficient space for safe storage of the resident's property, possessions, and furnishings and may be personalized and decorated to reflect the preferences of the individual. It also must permit access for the staff to complete their necessary health care functions. The number and size of bathrooms available must allow for the hygiene needs of each waiver participant and the ability of the staff to render care without spatial limitation or compromise.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Intermediate Care Facility for the Developmentally Disabled - Continuous Nursing

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Case Management/Coordination	☐
Habilitation Services	☐
Community Transition Services	☐
Continuouse Nursing and Supportive Services	☐
Environmental Accessibility Adaptations	☐
Home Respite	☐
Waiver Personal Care Services (WPCS)	☐
Personal Emergency Response (PERS) Installation and Testing	☐
Medical Equipment Operating Expense	☐
Family/Caregiver Training	☐
Facility Respite	☐
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	☑
Transitional Case Management	☐
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	☑
Private Duty Nursing - Including Home Health Aide and Shared Services	☐
Personal Emergency Response Systems (PERS)	☐

Facility Capacity Limit:

No more than eight individuals at any given time

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
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:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Home and Community-Based Continuous Care Facility - Congregate Living Health Facility (CLHF)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Case Management/Coordination	☐
Habilitation Services	☐
Community Transition Services	☐
Continuouse Nursing and Supportive Services	☑
Environmental Accessibility Adaptations	☐
Home Respite	☐
Waiver Personal Care Services (WPCS)	☐
Personal Emergency Response (PERS) Installation and Testing	☐
Medical Equipment Operating Expense	☐

Waiver Service	Provided in Facility
Family/Caregiver Training	☐
Facility Respite	☐
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	☐
Transitional Case Management	☐
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	☐
Private Duty Nursing - Including Home Health Aide and Shared Services	☐
Personal Emergency Response Systems (PERS)	☐

Facility Capacity Limit:

Up to 12 but most Home and Community-Based Continues Care Facilities have between 6 and 10.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
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:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

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*:

- **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-1/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.**
- **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-1/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 NF/AH Waiver services.

DHCS/IHO will authorize the participant's legal representative/legally responsible adult to provide NF/AH 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 NF/AH Waiver Standards of Participation (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 representatives/legally responsible adults who meet the Medi-Cal and NF/AH Waiver provider standards may provide the following NF/AH Waiver services:
• Case Management;
• Community Transition Services;
• Environmental Accessibility Adaptations;
• Family Training;
• Private Duty Nursing;
• Habilitation Services;

• Respite Home;
• Transitional Case Management; and
• Medical Equipment Operating Expense.

DHCS/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-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

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 NF/AH 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 a NF/AH Waiver provider is available online at the Medi-Cal website under the Provider Enrollment Branch (PEB). Provider enrollment information is also available in the Medi-Cal Provider Manual, provided at statewide DHCS/IHO presentations, and available on request by calling the DHCS/IHO Sacramento or Los Angeles office. The HCBS NF/AH Waiver Standards of Participation (SOP) are included in this waiver application.

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

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

The provider first must apply for and receive a National Provider Number (NPI) to include on the Medi-Cal Provider Application form. When that number is received the provider is instructed to return the completed provider application to DHCS/IHO. DHCS/IHO reviews the application to determine if the provider meets the waiver's SOP. Upon approval, DHCS/IHO transmits the application to PEB who will determine if the provider meets the Medi-Cal provider requirements. Upon PEB approval the provider is given a category of service code that allows them to render and be reimbursed for NF/AH 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 DHCS RN 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 CA-MMIS Provider Master File for licensed providers, and Case Management Information Payrolling System (CMIPS) for non-licensed providers.

ICF/DD-CN Residence Enrollment Plan

1. An Initial letter of interest needs to be sent by the potential ICF/DD-CN residence to DHCS/IHO.

2. The potential ICF/DD-CN residence will need to secure approval by the Standing Committee.

3. The potential ICF/DD-CN residence will submit an application to the Centralized Applications Unit of the California Department of Public Health (CDPH) for processing. Once complete, the application will be sent to the CDPH Coordinator.

4. The potential ICF/DD-CN residence will submit a ICF/DD-CN Program Plan to the Department of Developmental Services (DDS) for approval.

5. The CDPH and DHCS Community Options Monitoring and Assessment Unit (COMAU) will provide initial consultation to the ICF/DD-CN residence which will include:
- A review of the physical environment,
- A review of waiver requirements,
- A pre-licensing check list,
- A review of "level of care determination" for potential consumers.

6. DHCS will offer the ICF/DD-CN residence a provider contract.

7. A Centers of Medicare & Medicaid Services (CMS) Form 1539 will need to be completed for date of ability to participate in the federal program.

8. The ICF/DD-CN residence provider must apply for and receive a National Provider Number (NPI). The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearing houses will use the NPIs in the administrative and financial transactions adopted under HIPAA.

The NPI Toll-Free number is 800-465-3203.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. *Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of NF/AH Waiver providers that were licensed and/or certified and/or met the waiver provider requirements as described for each provider type in Appendix C-3 prior to furnishing waiver services.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of NF/AH Waiver providers that were evaluated for compliance with all Federal and State waiver requirements during a timely annual visit by DHCS staff.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of NF/AH Waiver providers that received a notice from the DHCS RN identifying areas of required corrections in regard to meeting waiver requirements.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of NF/AH Waiver providers that have the participant's chart current and up-to-date with a current physician signed POT.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of NF/AH Waiver provider files for RN and LVN independent providers that had a copy of a current and active California nursing license.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
CMIS Database Tracking and Reporting System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of enrolled ICF/DD-CN residences that demonstrate the ability to successfully complete nursing services as documented on the Continuous Nursing Care Tracker (CNCT)

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The percent of ICF/DD-CN residences with completed emergency evacuation plans.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of WPCS providers (non-licensed/non-certified individuals) with signed provider agreements indicating an understanding of the need to provide care in accordance with waiver requirements and the participant's POT.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of case files with documentation that the WPCS provider has been trained and has the necessary skills, competencies and qualifications.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
CMIS Database Tracking and Reporting System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of NF/AH Waiver provider files for RN and LVN independent providers that had a copy of a current life support certification and documentation of current continuing education.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):

Other
If 'Other' is selected, specify:
CMIS Database Tracking and Reporting System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
Percent of case files with an INP LVN providing waiver services with documentation by the RN Case Manager that the INP LVN was directly observed peforming their skilled duties and received training as necessary to be able to provide care in accordance with the participant's POT.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
DHCS RN staff will visit every participating facility at least once a year. The DHCS RN staff review the participant records and interview and/or assess the participants.

Residence visit findings will be documented by the DHCS RN using the Continuous Nursing Care Tracker (CNCT), an electronic review tool. A findings report will be produced from the site review data and transmitted to CDPH via secure e-mail within one week of the residence visit. If, during the visit, the DHCS RN staff encounters an issue requiring immediate action that has the potential to affect participant health and safety, the CDPH will be contacted by telephone.

The data that will be tracked includes:
1. LTCD residence visit general findings;
2. CDPH residence visit general findings;
3. Type and number of event and issues that affect the health and safety of the waiver participants;
4. Timeliness of reporting, documentation, resolution of issues and continuous improvement activities; and
5. Specific problems, complaints and issues related to participant care noted during the visit.

CDPH will also make annual residence visits. Issues identified by the CDPH will be followed up by CDPH according to policies and procedures for plans of correction for any identified provider deficiencies and/or practices.

Actions taken are based upon the severity of the findings and could include:
1. Technical assistance (TA);
2. A corrective Action Plan (CAP);
3. Required participation in statewide trainings, and/or
4. Increased oversight, penalties and sanctions including increased residence visits, staff trainings and telephone contacts.

Issues identified during the DHCS RN residence visit will be addressed with the provider during the exit interview and TA will be provided. A post-visit letter identifying issues, concerns and TA provided will be sent to the provider and copies to the CDPH within two weeks of the home review. The CDPH will take action, if necessary, and will communicate anticipated actions to the DHCS/IHO. Actions and issues will be entered into the CNCT for tracking and analysis. The QAU will conduct follow-up discovery activities as needed to determine the effectiveness of the remedial actions. Results will be provided to the LTCD management. QAU will also compile and aggregate CNCT data annually and present findings, actions and updates to the LTCD management.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
IHO assures that the waiver services delivered to NF/AH Waiver participants are provided by qualified waiver providers. IHO requires that all providers meet NF/AH Waiver Standards of Participation for each provider types, sign a Waiver Provider Agreement, and meet any Medi-Cal licensing and certification requirements prior to providing services to waiver participants. Documentation of current licenses and training are maintained at the IHO regional offices.

Provider performance is monitored by DHCS RN staff on an ongoing basis. Should deficiencies be reported to the DHCS RN or discovered during the annual provider visit the DHCS RN must create an Event/Issue Report with a plan of corrective action. The Event/Issue Report would include a description of the deficiencies/issues found, the plan to address/resolve the deficiency/issues and the resolution of the deficiency/issues. All Event/Issue Reports are monitored and reviewed by DHCS RN Supervisors until a resolution has been documented. In the event serious issues are found that would have a negative impact on the health or wellbeing of a waiver participant the issue would require the DHCS RN to report the issue to the appropriate local or State agencies such as Adult Protective Services (APS), Child Protective Services (CPS), local law enforcement, or the CDPH Licensing and Certification, as well as the DHCS RN Supervisor.

The QAU uses the Record Review Tool to aggregate data gathered during the annual Case Record Review to analyze statewide trends and provide problem resolution with technical assistance and training to RN staff when necessary.

Within 90 days of the Case Record Review, the QAU will present an analysis of the findings to the IHO Management Team, DHCS RN Supervisors and RN staff. Based upon the findings and level of compliance, remediation actions will be developed and implemented within 30 days by the IHO Managers, Supervisors, and QAU. QAU will follow up on the effectiveness of any redial action within 90 days. Remedial actions will be re-evaluated at the next year's annual Case Record Review.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

○ **No**

◉ **Yes**
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

DHCS/IHO has begun development of a Provider Satisfaction Survey. The survey is a mechanism to secure feedback from providers, to evaluate the provider's satisfaction with being a NF/AH Waiver provider, the effectiveness of the NF/AH 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 NF/AH Waiver and/or process. DHCS/IHO's goal is to conduct a survey early in 2012.
The timeline for this action is as follows:

1/1/08 – 4/30/08 – Conduct research on Provider Satisfaction Surveys and select a model. (COMPLETED)

1/1/10 – 8/31/11 – Develop a survey, instructions and evaluation criteria. Have appropriate DHCS/IHO Managers review and approve the survey and instructions. (COMPLETED)

1/1/12 – 2/15/12 – Issue and collect the survey by mail with possible follow-up by DHCS RN staff to help ensure a reasonable percentage of input by providers.

2/16/12 – 3/31/12 – Analyze and evaluate the results of the survey by provider type and present findings to DHCS Management Team and RN staff.

6/1/12 – 8/31/12 – Develop any necessary remediation plans based upon results of survey and any findings discovered during provider visits.

1/1/13 – 3/31/13 – QAU will follow-up with providers to determine and document the effectiveness of any remedial or corrective action.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes 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; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- [ ] **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.

- [ ] **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.

☐ **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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Plan of Treatment (POT)

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 *(select each that applies):*

- [x] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, 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-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

- [ ] **Social Worker.**

  Specify qualifications:

- [ ] **Other**

  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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.**
- (•) **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:*

A NF/AH Waiver case management/coordination provider who meets the service requirements set forth in Appendix C-3 which includes the NF/AH 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.

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 by the entity and/or individual responsible for service plan development, the DHCS RN will review the POT to determine that the requested waiver services are medically necessary and that the amount, frequency, duration, and provider type of each service is included. 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 DHCS RN 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 DHCS RN 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.

For purposes of the developmentally disabled individual choosing to receive waiver services in their home or an ICF/DD-CN residence, statutory requirements are met using the Individual Program Plan (IPP) developed by the Regional Center, or for children under 36 months, the Individual Family Service Plan (IFSP); the Individual Service Plan (ISP) developed by the ICF/DD-CN if services are to be rendered at the residential facility; and the medical POT developed by the participant's case manager. This process will be referred to as the "plan of care." The plan of care is the fundamental tool by which the State will ensure the health and welfare of developmentally disabled participants receiving waiver services. As such, the plan of care will be subject to periodic review by DHCS. DHCS RNs review the plans of care during their onsite monitoring reviews at least every 12 months, or more often if unannounced visits or extra onsite visits are needed. DDS regional centers review the IPP and IFSPs every three months or when there is a significant change. These reviews will determine the appropriateness and adequacy of the waiver services and will ensure that the services are consistent with the nature and severity of the participant's disability, as well as medical and nursing needs. FFP will not be claimed for State Plan services that are not included in the plan of care.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

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, 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 DHCS RN 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 DHCS RN 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 DHCS RN is available to assist the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support with information on 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 DHCS RN 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's, his/her primary caregiver's, the primary care physician's, HCBS waiver service provider's, and DHCS' roles and responsibilities in the development and implementation of the POT.

Waiver Services – Plan of Care for the developmentally disabled individual choosing waiver services in their home

or an ICF/DD-CN as the residential facility:

1. Individual Program Plan (Regional Center)

The regional centers use a planning process call an Individual Program Plan (IPP). For children age 0 to 36 months old, this process is called the Individual Family Service Plan (IFSP). The IPP/IFSP is developed through a process of individualized needs determination, and is prepared jointly by the planning team. The planning team consists of the individual with developmental disabilities or the parents of a minor child and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, and an authorized regional center representative, or anyone else the individual invites to participant.

The IPP/IFSP lists goals and the services needed to reach those goals. It lists who will provide the service and who will pay for it. All services listed in the IPP/IFSP will be provided either by a generic or natural resource, a regional center vendor (a business approved by the regional center) or directly by the regional center.

2. Individual Service Plan (ISP) – ICF/DD-CN

Regulations in Title 22, CCR, Section 76860, state in part that an Individual Service Plan (ISP) is a plan developed for each individual participant by the residence's interdisciplinary professional staff/team, and will have the following information:

a. Implements the prescriptive requirements of the regional center's IPP/IFSP.

b. Is based on assessment data pursuant to Title 22, CCR, Section 76859 and is completed within 30 days following admission.

c. Is developed by the residence's interdisciplinary professional staff/team, and includes participation of the waiver participant, direct care staff, and should include all relevant staff of other agencies involved in serving the participant. Prior to development of the ISP, the participant's parents, if the participant is a minor, or the participant's authorized representative shall be invited to attend the service plan conference.

d. Identifies the participant's developmental, social, behavioral, recreational and physical needs.

e. Includes established prioritized objectives, written in behavioral and/or developmental terms that are measureable and time limited, for meeting the participant's identified needs.

f. Identifies the method and frequency of evaluation.

g. Includes a daily program schedule that specifies the time and duration of all ADLs; and time, duration, and location of all specified programs.

h. Specifies the persons and agencies responsible for implementing and coordinating the service plan.

i. Contains monthly progress notes related to the service plan, goals and objectives.

j. Includes when discharge is anticipated, plans for services, including the specific agencies or persons responsible for those follow-up services in the participant's new environment.

3. Individual Plan of Care – Medical and Nursing Staff or Health Care Professional

Regulations in Title 22, CCR, Section 73311, state in part that nursing services shall include, but not be limited to, the following:
a. Identification of problems and development of an Individual Plan of Treatment (POT) for each participant based upon initial and continuing assessment of the participant's needs by the nursing staff and other health care professionals. The POT shall be reviewed and revised as needed but not less often than quarterly.

b. Notification of the attending physician immediately of any participant exhibiting unusual signs or behavior.

c. Ensuring that participants are served the diets as prescribed by attending physicians, and that participants are provided with the necessary and acceptable equipment for eating and that prompt assistance in eating is given when needed.

d. Any marked or sudden change in weight shall be reported promptly to the attending physician.

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/coordinator is responsible for developing the POT. A waiver case manager/coordinator can be:

• A RN licensed to practice in the State of California, who is employed by a Home Health Agency or CLHF 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, individuals with a Baccalaureate degree or higher in Clinical Social Work, Social Welfare, Psychology, Marriage and Family Therapy or Gerontology.
• The participant's primary care physician must participate in the development of the POT.

DHCS policies and procedures require that the participant's waiver case manager/coordinator 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/coordinator 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/coordinator, consulting with the primary care physician, must submit an updated primary care physician-signed POT to the DHCS RN. "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.

If the participant's only service is WPCS then the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support are responsible for developing the POT with the assistance of the DHCS RN.

The DHCS RN 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/coordinators can use either the "Long-Term Care Division, In-Home Operation's, 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, frequency, duration 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/coordinator 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 DHCS RN reviews the completed POT to verify the participant's care needs, the frequency and duration of waiver and state plan services, providers, and the participant's goals. Back-up systems are also identified. The DHCS RN's review of the POT is conducted during the initial request for NF/AH Waiver services, during the reevaluation of the participant's LOC, at the annual provider visit, and with each request for waiver services. The DHCS RN 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 DHCS RN provides information to the participant and/or his/her legal representative(s), and/or circle of support on the NF/AH 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 DHCS RN in the development of a home care program, and to ensure the home program meets the NF/AH 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 DHCS RN 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 DHCS RN reviews the effectiveness of meeting the goals described in the POT during the LOC reevaluation home visit.

(e) The waiver case manager/coordinator is primarily responsible for assisting the participant with coordination of waiver and State Plan services. The waiver case manager/coordinator 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 DHCS RN 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/coordinator 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 DHCS RN reviews the POT while conducting the LOC reevaluation. During the reevaluation, the DHCS RN 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/coordinator is required to be present during the participant's scheduled reevaluation. Annually, the DHCS RN conducts the provider visit with the waiver case manager/coordinator to review the participant case record and the participant's home program, including implementation of the elements of the POT. The DHCS RN, together with the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support, and waiver case manager/coordinator prepares a plan for 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/coordinator, consulting with the primary care physician, must submit an updated or revised POT to the DHCS RN. "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.

Waiver Services – Plan of Care for the developmentally disabled individual choosing waiver services in their home or an ICF/DD-CN residential facility:

For purposes of the developmentally disabled individual choosing to receive waiver services in their home or an ICF/DD-CN residential facility, statutory requirements are met using the IPP developed by the Regional Center, or for children under 36 months, the IFSP; the ISP developed by the ICF/DD-CN if services are to be rendered at the residential facility; and the medical POT developed by the participant's case manager. This process will be referred to as the "plan of care." The plan of care is the fundamental tool by which the State will ensure the health and welfare of developmentally disabled participants receiving waiver services. As such, the plan of care will be subject to periodic review by DHCS. DHCS RNs review the plans of care during their onsite monitoring reviews at least every 12 months, or more often if unannounced visits or extra onsite visits are needed. DDS regional centers review the IPPs every three months or when there is a significant change. These reviews will determine the appropriateness and adequacy of the waiver services and will ensure that the services are consistent with the nature and severity of the participant's disability, as well as medical and nursing needs. FFP will not be claimed for State Plan services that are not included in the plan of care.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

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/coordinator's nursing evaluation and proposed interventions enabling the participant to live safely at home in the community. The DHCS RN 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/coordinator, service provider, and the 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, and evaluation regarding the potential for abuse, neglect and exploitation). Identified conditions that may affect the participant's health, welfare, and/or safety require the waiver case manager/coordinator 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 NF/AH 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 DHCS RN 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 DHCS RN 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 DHCS RN. When needed, the DHCS RN can assist the participant and/or legal representative/legally responsible adults in locating waiver service providers.

The initial contact with potential participants (and their representatives) includes a discussion of the CLHF and ICF/DD-CN residential facilities that may be available. The participant is presented with the options available with a discussion of the similarities and distinctions between the two resident types, the criteria for acceptance into the residencies and the similarities and distinctions between waiver services provided in the residencies and those provided in the participant's home. CLHF and ICF/DD-CN providers are encouraged to provide information, both oral and written to ensure that the participants have the information they require to make an informed choice.

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 DHCS RN is responsible for approving the POT. A current POT must be submitted to DHCS at the initial waiver enrollment and with each TAR for authorization of waiver services. The DHCS RN 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 NF/AH 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 NF/AH 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**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- [x] **Medicaid agency**
- [ ] **Operating agency**
- [x] **Case manager**
- [ ] **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

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.

• The DHCS RN and waiver case manager/coordinator 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.

• The DHCS RN and waiver case manager/coordinator 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/coordinator is responsible for regularly apprising the DHCS RN of the participant's status and reporting any unforeseen issues or problems that could negatively affect the participant.

The waiver case manager/coordinator is responsible for maintaining participant case notes documenting the participant's health status and identified problems and issues. The waiver case manager/coordinator 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 DHCS RN regularly reviews the waiver case manager/coordinator'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 DHCS RN asks if they are satisfied with the plan of correction and resolution.

At the home visit, the DHCS RN 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 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 DHCS 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 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 DHCS RN 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 in the POT are discussed with the waiver case manager/coordinator, 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 physician, before additional waiver services and/or continued enrollment in the NF/AH Waiver can be authorized by DHCS. Health and safety issues described in the POT are documented using the Event/Issue Report and included in the participant's case record.

On enrollment into the NF/AH Waiver, the intake DHCS RN reviews the initial POT with the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support. Ninety (90) days after the case is transferred to Case Management and the participant begins receiving waiver services, the DHCS RN conducts a home visit to assess how the participant is coping. The DHCS RN 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 DHCS RN 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 DHCS RN maintains contact with the participant and the waiver case manager/coordinator. 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/coordinator, the DHCS RN 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 waiver case manager/coordinator is responsible for submitting the revised POT to the DHCS RN for review and approval.

b. Monitoring Safeguards. *Select one:*

- (●) **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 D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**
   i. **Sub-Assurances:**

      a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of case records that document that the participant, his/her legal representative and/or their circle of support were involved in the identification, development and management of services and supports for meeting the participant's needs.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of POTs that documented all waiver and non-waiver services.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of case records documenting that the participant's needs are being met and that the participant, their legal representative and/or their circle of support are satisfied with the services being delivered.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of POTs signed by the primary care physician thereby indicating that the primary care physician agrees that the services meet the participant's needs to remain safely at home.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Participant/family observation/opinion
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

		☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Program logs
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of POTs signed by all waiver service providers thereby indicating that all waiver providers understand the services to be provided to the waiver participant.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other**	☑ **Annually**	

Specify:		☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percent of case reports that document services are delivered as described on the POT.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
CMIS Database Tracking and Reporting System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of current POTs found during the annual Case Record Review indicating service plans are updated/revised at least annually or when warranted by changes.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of case reports with documentation by the DHCS RN indicating that services are being delivered as described on the POT.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of case reports with documentation that corrective action was taken if services were not delivered as described in the POT.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of NF/AH Waiver participants whose case record contains a signed Freedom of Choice document stating they were informed of the choice of receiving care in their home and community in lieu of facility care.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
CMIS Database Tracking and Reporting System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of case records reviewed that have copies of the Informing Notices indicating they have been sent to the participant, provider, and primary care physician describing their responsibilities.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

		☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of case records indicating Medicaid freedom of choice as evidenced by the presence of a current MOHS which lists all waiver services and provider types and identifies the services and providers the participant or legal representative have selected.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of case records with a current MOHS that identifies all services described on the participant's POT.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
IHO assures that:
• the waiver participant and/or their circle of support are involved in identifying and managing the services that meet the waiver participant's needs and that the participant is satisfied with how those services are being delivered;
• the primary care physician is in agreement the participant is receiving the services necessary to remain safely at home;
• the waiver service providers deliver those services as described on the participant's POT and that corrective action is taken if they are not;
• the participant has been informed they have a choice to receive care in their home in lieu of facility care; and,
• the participant, the primary care physician and waiver providers have been informed of their rights and responsibilities under the waiver.

These assurances are monitored by DHCS RN staff on an ongoing basis. If an issue/problem is reported to the DHCS RN or discovered during a scheduled home visit the DHCS RN must create an Event/Issue Report with a plan of corrective action. The Event/Issue Report would include a description of the issue/problem, the plan to address/resolve the issue/problem, and the resolution of the issue/problem. All Event/Issue Reports are monitored and reviewed by DHCS RN Supervisors until a resolution has been documented. In the event serious issues are found that would have a negative impact on the health or wellbeing of a waiver participant the issue would require the DHCS RN to report the issue to the appropriate local or State agencies such as Adult Protective Services (APS), Child Protective Services (CPS), local law enforcement, or the CDPH Licensing and Certification, as well as the DHCS RN Supervisor.

The QAU is responsible for developing discovery activities, as well as collecting, and analyzing the data from those activities. IHO Management, DHCS RN Supervisors, and QAU are responsible for the development, implementation, and evaluation of remediation actions.

The QAU 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).

CMIS is a database developed and implemented in 2005. QAU uses information from CMIS to establish quality indicators that help determine if changes need to be made to the waiver enrollment criteria, services, providers, or any other aspect of waiver administration. CMIS allows IHO to document the utilization 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 QAU is responsible for conducting the annual Case Record Review on active NF/AH 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.surverysystem.com/sscalc.htm.

The QAU randomly selects a sample of case records with a 95% level of confidence with a 5% interval for the entire NF/AH 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 QAU selects the cases for review based upon the corresponding percentage of participants at each level of care (LOC) by IHO field office locations, and ensures that all RN 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's, and/or their circle of support's involvement in the development of the Plan of Treatment (POT);
• The POT appropriately addresses all of the participant's identified needs and assures the participant's health and welfare;
• The participant's, and/or their 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;
• Information and support is available to help The participant's, and/or their 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 RN's level of compliance with program policies and procedures in the completion and maintenance of the waiver participant's case records.

Using these tools, the QAU analyzes data for trends and patterns and makes changes to policy, procedures, and resources based on that analysis. The QAU then develops any needed remedial actions deemed necessary to provide the best service to the NF/AH Waiver population while assuring compliance with waiver assurances as well as IHO policies and procedures.

Within 90 days of the QA review, the QAU will present an analysis of the findings to the IHO Management Team. The analysis will include an evaluation of the waiver's impact to participant health and welfare and identify any risks to participants and how those risks will be managed. Based upon these findings and level of compliance, remediation actions will be developed and implemented by the IHO Managers, Supervisors, and QAU within 90 days. Effectiveness of the remediation actions are measured during the following year's annual Case Record Review. If the findings have a direct impact on a participant's health and safety the remediation actions will be measured within 90 days with any necessary follow up.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **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.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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.

Nursing Facility/Acute Hospital (NF/AH) 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.

DHCS/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. DHCS/IHO advises the participant or legal representative on the roles and responsibilities for the participant or legal representative, primary care physician, DHCS/IHO and the provider of waiver services. Upon request the DHCS/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 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
• Habilitation Services
• Community Transition Services
• Private Duty Nursing

• Transitional Case Management
• Family Training
• Respite Care

Participants or legal representative may hire individual licensed providers to facilitate the provision of and Medi-Cal billing for the following services:

• Environmental Accessibility Adaptations
• Personal Emergency Response Systems – Installation and Testing
• Personal Emergency Response Systems
• Medical Equipment Operating Expenses

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 DHCS/IHO or they can select an unlicensed or licensed provider who is not yet enrolled as provider. Upon selecting an unlicensed or licensed provider that is not currently enrolled as a Medi-Cal provider, DHCS/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 rending waiver services.

Prior to rendering care, licensed providers that have been selected by the participant or legal representative must submit to DHCS/IHO the required documentation that is described in the Standards of Participation for the individual's provider type. DHCS/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.

DHCS/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 DHCS/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 a corrective action plan will be developed. DHCS/IHO will interview the participant or legal representative as to the effectiveness of the action plan. In the event issues affect or may affect the health and safety of the participant, DHCS/IHO will complete an Event/Issue Report, contact the primary care physician and the appropriate law enforcement, child or adult proactive services, as applicable.

DHCS/IHO instructs the participant or legal representative to notify DHCS/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 DHCS/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.

DHCS/IHO must be in receipt of a current POT describing all the services the participant receives and who provides the 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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

- (●) **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 these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- (●) **The waiver is designed to afford every participant (or the participants 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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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.

DHCS/IHO staff will 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 Waiver Personal Care and/or Respite services DHCS/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, DHCS/IHO and the unlicensed provider. The packet includes the following information:

• 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 Waiver Personal Care services;

• Waiver services can only be authorized upon DHCS/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 DHCS/IHO upon the hiring and dismissal of providers.

If the participant or legal representative selects a licensed provider to provide case management, private duty nursing, medical equipment operating expenses family training and/or respite care services DHCS/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 responsible for notifying DHCS/IHO upon the hiring or dismissal of providers.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

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:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Case Management/Coordination	☑	☐
Habilitation Services	☑	☐
Community Transition Services	☑	☐
Continuouse Nursing and Supportive Services	☑	☐
Environmental Accessibility Adaptations	☑	☐
Home Respite	☑	☐
Waiver Personal Care Services (WPCS)	☑	☐
Personal Emergency Response (PERS) Installation and Testing	☑	☐
Medical Equipment Operating Expense	☑	☐
Family/Caregiver Training	☑	☐
Facility Respite	☑	☐
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	☑	☐
Transitional Case Management	☑	☐
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	☑	☐
Private Duty Nursing - Including Home Health Aide and Shared Services	☑	☐
Personal Emergency Response Systems (PERS)	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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**

◉ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Answers provided in Appendix E-1-h indicate that you do not need to complete this section.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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)*:

☑ **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.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Case Management/Coordination	☐
Habilitation Services	☑
Community Transition Services	☐
Continuouse Nursing and Supportive Services	☐
Environmental Accessibility Adaptations	☐
Home Respite	☐
Waiver Personal Care Services (WPCS)	☐
Personal Emergency Response (PERS) Installation and Testing	☐
Medical Equipment Operating Expense	☐
Family/Caregiver Training	☐
Facility Respite	☐
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	☐
Transitional Case Management	☐
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	☐
Private Duty Nursing - Including Home Health Aide and Shared Services	☐
Personal Emergency Response Systems (PERS)	☐

☑ **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:

DHCS/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 DHCS RN.

The DHCS RN is required to advise 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 representative. Evidence of the participant being informed of the option is documented in the DHCS/IHO Case Report and copies of the Informing Notice and Menu of Health Services is filed in the participant's DHCS/IHO case record.

At each participant reassessment visit the DHCS RN interviews the participant or legal representative as to the effectiveness of the provider's ability to provide the services as described on the POT. At each annual provider visit the DHCS RN assesses 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 DHCS/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 DHCS/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.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **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:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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:

NF/AH Waiver participants can elect to terminate participant direction services at any time. The participant or legal representative is advised to call the participant's assigned DHCS RN upon the decision to terminate services. The DHCS RN 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. DHCS/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 DHCS/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 is unable to secure an alternative provider DHCS/IHO will offer to transition the participant to a licensed medical facility until a new provider can be secured.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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 provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

DHCS/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 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 the 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's or legal representative's 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 DHCS/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.

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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	3276	
Year 2	3448	
Year 3	3620	
Year 4	3792	
Year 5	3964	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

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. *Select one or both*:

- [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 (DSS) acts as a 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. *Select one or more 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-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [ ] **Determine staff wages and benefits subject to 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:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

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

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **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-1/C-3**
- ☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/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:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. **Participant - Budget Authority**

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. **Participant - Budget Authority**

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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 under 42 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) 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 Nursing Facility/Acute Hospital (NF/AH) 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 Department of Health Care Services (DHCS) Notice of Action (NOA) letters. A NOA is sent to the participant or his/her legal representative/legally responsible adult(s) when a request for enrollment in the waiver is denied, or when a service has not been approved as requested or is reduced, terminated, or denied by DHCS/In-Home Operations (IHO).

The DHCS RN 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 DHCS/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 Hearings 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 DHCS RN.

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 met regular Medi-Cal eligibility requirements.

Upon request of a State Fair Hearing, DHCS/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, and advise them they will receive the DHCS 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, DHCS/IHO will refer the participant and/or his/her legal representative/legally responsible adult(s) to the toll-free phone number on the back of the NOA for information regarding hearing rights, free legal aid, and information regarding Protection and Advocacy, Inc.. DHCS/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's scheduled date. If a hearing is held the DHCS Director's Decision upholds DHCS/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 may 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 reduction, or termination of waiver services:

• The cost of the requested service(s) exceeds the cost of the identified institutional alternative and the participant, their legally responsible adult(s), 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 NF/AH 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 an 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 DHCS/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 the 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 DHCS RN 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 order 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 DHCS/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) 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 Waiver Personal Care Services (WPCS), 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), primary care physician, or waiver service provider has not submitted to DHCS/IHO a complete and current primary care physician-signed POT within 90 days of notification that he/she is eligible for enrollment in the NF/AH Waiver or within 60 days of the end-date of the previous POT; and

• DHCS/IHO has not authorized a waiver service within 90 days of notification that he/she is eligible for enrollment in the NF/AH Waiver or within 60 days of the termination date of the last authorized waiver services.

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

Appendix F: Participant-Rights

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:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

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: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- (●) **No. This Appendix does not apply**
- ( ) **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**

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. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. 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 DHCS RN will act on and document all reported or observed critical events or issues that may affect the health, safety and welfare of waiver participants as they are discovered. Critical events or incidents are incidents of participant abuse, (verbal, sexual, physical, or mental) 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 DHCS RN provides instruction to the participant, his/her legal representative/legally responsible adult(s) and/or members of his/her circle of support annualyy on how to report events or issues that affect or can affect the health, safety and welfare of the waiver participant.

The DHCS RN will use the Event/Issue Report form to document concerns or problems expressed by the participant, his/her legal representative/legally responsible adult(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 DHCS RN, the DHCS RN 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 includes:

• 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 DHCS RN to report the incident to the supervising DHCS RN and to the appropriate local or State agencies. DHCS/IHO will adhere to the Health Insurance Portability and Accountably Act of 1996 to ensure the participant's Personal Health Information is protected. The DHCS RN 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 Department of Public Health (DPH), Licensing and Certification (L&C) on events/issues affecting participants that are related to home health agencies (HHA), pediatric day health care (PDHC) providers, congregate living health facilities (CLHF), intermediate care facilities for the developmentally disabled-continuous nursing (ICF/DD-CN) 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)and 1250(m) (ICF/DD-CN). After consulting with the Supervising DHCS RN, the DHCS RN 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) 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 in 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 DHCS RN 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.

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

The DHCS RN is responsible for informing and discussing with the participant, his/her legal representative/legally responsible adult(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 DHCS RN 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 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 waiver services provider. It also includes information on how to notify the DHCS RN if there are any issues or concerns that may impact the safety, health, and welfare of the participant.

The DHCS RN evaluates the participant for issues of abuse, neglect, and exploitation during the initial face-to-face visit and at each reevaluation visit. The DHCS RN 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 DHCS RN 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 DHCS RN, the DHCS RN will document the incident using the Event/Issues Report form and update the participant's case file 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 DPH L&C.

d. 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 waiver provider, the provider has the responsibility to notify the DHCS RN, and if applicable, other agencies (CPS, APS, or law enforcement). When an event/issue is identified by, or reported to the DHCS RN, the DHCS RN 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 DPH, L&C. Any contact made with other agencies or individuals will be kept confidential.

The DHCS RN will discuss the issues with the DHCS RN Supervisor and develop a plan of resolution. All plans developed to resolve identified problems are thoroughly evaluated by the DHCS RN 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 DHCS RN with a waiver provider, 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 DHCS RN. The DHCS RN will continue to follow-up with the waiver provider(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 DHCS RN 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 DHCS RN will discuss the issue(s) with the DHCS RN 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 waiver provider, the waiver provider shall submit written documentation to the DHCS RN for review. The waiver provider and the DHCS RN 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 DHCS RN 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 DHCS RN will contact the appropriate agency and provide the necessary information and documentation to assist in the investigation. The DHCS RN will continue to follow-up with the appropriate agency and keep the DHCS RN Supervisor and the participant informed of the situation.

Events/issues referred to DPH, L&C are tracked to ensure that DHCS/IHO can adequately respond to the reported findings and plan for resolution of the event/issue. The DHCS RN 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.

e. 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 DHCS/IHO Quality Assurance Unit (QAU) 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 QAU 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.

The QAU conducts an annual quality management case record review to determine: 1) if the DHCS/IHO staff are completing and submitting the event/issue report for all events and issues that may or are affecting the participant's health and safety to the QAU; 2) whether an appropriate action plan was developed and the outcome of the action

plan; and 3) whether systemic program issues exist that require remediation. The annual findings of the Case Record Review are documented in an annual report prepared by the QAU. Based upon the information in the annual report, DHCS/IHO Management Team will develop action plans to address deficiencies in reporting and/or identified systemic issues.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

○ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

◉ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

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).

The DHCS RN 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 DHCS RN and/or via telephone contact with participants, his/her legal representative/legally responsible adult (s), waiver providers, and primary care physician. If the waiver provider or the DHCS RN observes or learns that restraints or seclusion are being used, an Event/Issue Report form must be completed. The DHCS RN 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.

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:

If the DHCS RN 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, PDHC, CLHF or ICF/DD-CN is referred to DPH, L&C to investigate and report on their findings. The DHCS RN is responsible for monitoring DPH, L&C's investigation and findings.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The DHCS RN 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 DHCS RN and/or via telephone contact with participants, his/her legal representative/legally responsible adult(s), waiver

providers, and primary care physician. If the waiver provider or the DHCS RN observes or learns that restrictive interventions are being used, an Event/Issue Report form must be completed and the appropriate law enforcement and either child or adult protective services be will contacted to report the event. Unauthorized use of restrictive interventions by a HHA, PDHC, CLHF or ICR/DD-CN is referred to DPH, L&C to investigate and report on their findings. The DHCS RN is responsible for monitoring DPH, L&C's investigation and findings.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

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:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

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:

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

A Congregate Living Health Facility (CLHF) enrolled as a Home and Community-Based Continuous Care Facility (HCBCCF) waiver provider and an ICF/DD-CN residence is responsible for medication management for waiver participants unless the participant has a primary care physician order to self-manage his/her medications.

A Registered Nurse (RN) employed by the CLHF or ICF/DD-CN is required to complete an initial assessment that includes reviewing medications to ensure the participant's medication needs are identified during the assessment process and are reviewed and updated as necessary based on the participant's changing medication needs and their primary care physician orders. The RN documents the start date, stop date, dosage and scheduled times of each medication to be provided.

Waiver participants residing in a CLHF or ICF/DD-CN may keep and take their own medications when authorized to do so by their personal physician. For those who need help with self-administration the CLHF or ICF/DD-CN staff will assist participants with self-administration or administer medications in accordance with their license as necessary.

The California Department of Public Health (CDPH) makes at a minimum, annual visits to the CLHF and ICF/DD-CN facilities. DHCS RNs also make annual visits. Regional Center staff visit the ICF/DD-CN facilities every 6 months. During these visits, each of these entities has both the authority and responsibility to

monitor medication regimens and ensure that the participants are receiving the correct, therapeutic medications as ordered and scheduled. This is achieved by reviewing the physician's orders and the medication records.

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.

State oversight is provided by the DHCS RN staff and followed up by the California Department of Public Health (CDPH)at annual provider visits.

The DHCS RN performs extensive client chart reviews at annual provider visits and situations of potentially harmful practices receive the appropriate follow-up. The DHCS RN as well as licensed nursing staff of the CLHF or ICF/DD-CN residence are trained to identify the concurrent use of contraindiated medications. If situations of inappropriate follow-up are found to have occurred, the DHCS RN provides education and training on corrective actions to handle such situations in the future. At subsequent program compliance reviews, the DHCS RN will follow-up regarding previous findings to ensure that necessary changes have occurred and continue to be applied, and that corrective actions are assuring client health and welfare. Through these reviews, the DHCS RN assesses and evaluates the regular management of participant medications by qualified nursing staff at the CLHF or ICF/DD-CN.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **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)*

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).

Only a licensed nurse (RN or LVN) may administer a medication.

Unlicensed CLHF or ICF/DD-CN staff have the ability to assist waiver participants by passing medications or opening syringes and handing them to the participant but the participant must have the ability to self-administer the medication or the services of a LVN or RN are required. This requirement is enforced by CDPH.

Under the NF/AH waiver the CLHF and ICF/DD-CN are required to have skilled nursing staff sufficient to meet the skilled nursing needs of all waiver participants. If the participant is unable to take medication with assistance the CLHF or ICF/DD-CN is responsible for providing the licensed nurse as needed.

The DHCS RN works with CLHF and ICF/DD-CN nursing staff to ensure that persons responsible for the administration of medications are trained to ensure appropriate medication management and client education. The DHCS RN documents any findings of harmful and/or noncompliant practices which are found and follows up with the DHCS RN Supervisors with their plan for resolution and tracks remediation efforts to improve program performance. The DHCS RN, as well as CDPH reviews the following:
• Medication storage;
• Self-administered medications;
• Medication procedures;
• Medication documentation;

• Scheduled and controlled drugs, usage and storage; and
• PRN medications, usage and disposal.

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:

The DHCS RN makes, at a minimum, annual visits to the CLHF and ICF/DD-CN. During these visits, the DHCS RN has the authority and responsibility to monitor medication regimens and ensure that the participants are receiving the correct, therapeutic medications as ordered and scheduled. This is achieved by reviewing the physician orders and the medication records.

CLHF and ICF/DD-CN waiver providers must have skilled nursing staff (RN or LVN) in the residence at any time a participant is present. The skilled nursing staff is responsible for medication administration.

CLHF and ICF/DD-CN providers are required to document all medication errors and report the errors that constitute a risk to participant health and safety to the DHCS RN. The report must include information regarding the medication, the error, and the outcome to the extent that it is known at the time of the report.

(b) Specify the types of medication errors that providers are required to *record:*

Medication errors that occur when a participant is under a provider's care, including those where the provider is assisting the participant to self-administer.

(c) Specify the types of medication errors that providers must *report* to the State:

Medication errors that constitute a risk to the participant's health and safety and occur when a participant is under a provider's care, including those where the provider is assisting the participant to self-administer.

○ **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.

Medication errors are reported to DHCS and CDPH for follow-up at least bi-annually.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number of events/issues reported in the Event/Issue database by type

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of NF/AH Waiver cases meeting DHCS/IHO's policies and procedures requiring issues or events to be documented in the Event/Issue database.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of events/issues that have documentation indicating they have been resolved during the previous year.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Source (Select one):
Program logs
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of case records documenting the NE has discussed recognizing instances of abuse, neglect or exploitation with the participant, family and/or circle of support.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of case records documenting that the participant, family and/or circle of support are aware of how to report instances of abuse, neglect or exploitation.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The DHCS RN will act on and document all reported or observed critical events or issues that may affect the health, safety and welfare of waiver participants as they are discovered. Incidents of possible abuse, neglect or exploitation require the DHCS RN to report the incident to the supervising DHCS RN and to the appropriate local or State agencies.

Following the annual Case Record Review, the QAU will present an analysis of the findings from the Case Record Review to the IHO Management Team within 90 days. Based upon the findings and level of compliance, remediation actions will be developed and implemented by the DHCS/IHO Managers, Supervisors, and QAU within 90 days. Effectiveness of the remediation actions will be re-evaluated at the next annual Case Record Review.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

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 Improvement 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.

CMS recognizes that a state's waiver Quality Improvement 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 Improvement 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 Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement 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 Improvement Strategy, including the specific tasks the State plans to undertake during the period 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 Improvement 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/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The DHCS/IHO Management Team is responsible for establishing priorities, remediation and improvement actions. DHCS/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 all reports and reviews EXCEPT those having to do with participant health and safety. In addition to the levels of assurance, the state remediates all errors upon discovery. DHCS/IHO' expectation is 100% compliance in the area of health and safety.

Compliance Levels for all Assurances EXCEPT Health and Safety Assurances:

• 90%-100%: Substantial compliance with NF/AH Waiver assurances and/or DHCS/IHO Policy & Procedure. No significant remediation actions required.

• 80% - 89%: Compliant with NF/AH Waiver assurances and/or DHCS/IHO Policy & Procedure but raises concerns. Additional investigation is needed. Remediation action and follow-up focus review as needed.

• 70%-79%: Marginally compliant with IHO Waiver assurances and/or DHCS/IHO Policy & Procedure. Remediation action and follow-up focus review required.

• 69% or Less: Non-compliant with NF/AH Waiver assurances and/or DHCS/IHO Policy & Procedure. Remediation action and follow-up focus review is required.

The Level of Compliance score is used to determine the priority in the development and implementation of remediation activities. Level of Compliance scores of less than 69% will require immediate action. A remediation plan will be developed and implemented within 60 days after the findings are presented to the DHCS/IHO Management team. A follow-up focus review will be conducted 90 to 120 days after implementation of the remediation plan to determine the effectiveness of the plan. Results of the review will be presented to the DHCS/IHO Management Team for future planning.

Compliance scores of 70%-79% will have the next priority and will also require a remediation plan and follow -up focus review. Areas with a compliance review score of 80%-89% will be further investigated and the DHCS/IHO Management Team will determine if there is a need for a remediation plan or if the findings were an aberration. When DHCS/IHO is unable to address all areas of concern, priority will be given to those findings that may directly affect the waiver participant. Follow-up focus review will only be conducted on participant related issues. Effectiveness of remedial actions related to DHCS RN compliance with internal policies and procedures will be measured at the annual review. Results of all reviews will be present to the DHCS/IHO Management Team for future planning.

Compliance Levels for all Health and Safety Assurances

• Regardless of the level of compliance, program issues that affect the immediate health and safety of the participant will receive priority action. Any issues will be brought to the attention of the DHCS/IHO Management Team and a remediation plan will be developed and implemented. The remediation plan may include contacting other agencies and State Departments for assistance, discussion at quarterly Olmstead Advisory Stakeholder meetings, changes to DHCS/IHO Policy & Procedure and/or requesting assistance from CMS.

DHCS/IHO' QAU generates Administrative Management Reports on a regular basis. The following is a list of the major reports generated, the topic, frequency, and the recipients of the report.

Home Visit Overdue Report
List of participants whose re-evaluation visit is over due by 30 days or more
Frequency: Monthly, Quarterly, Annually
Recipients: DHCS RN Supervisors, IHO Management

Provider Visit Overdue Report
List of waiver providers whose annual visit is overdue by 30 days or more
Frequency: Monthly, Quarterly, Annually
Recipients: DHCS RN Supervisors, IHO Management

Event/Issue Report
By issue, amount of time to resolve an issue and participant satisfaction
Bi-annually, Annually
Recipients: IHO Management

Fair Hearing Report
By issue and outcomes
Annually
Recipients: IHO Management

Outreach Activities
List of outreach activities, who attended, and average evaluation scores
Annually
Recipients: IHO Management

Incidents involving ICF/DD-CN residences are also reported to CDPH. These include, but are not limited to:

• Hospitalization and/or emergency room transfer
• Facility transfer/discharge
• Accident with injury
• Death
• Any unusual occurrence

CDPH has the authority through H&S Code §1420 to investigate and determine the required remediation.

Incidents involving ICF/DD-CN residences are also reported to CDPH. These include, but are not limited to:
• Hospitalization and/or emergency room transfer
• Facility transfer/discharge
• Accident with injury
• Death
• Any unusual occurrence

CDPH has the authority through H&S Code §1420 to investigate and determine the required remediation.
CDPH will maintain a reported event/complaint log of incidents, complaints and exceptional events/unusual occurrences.

a. Reported Events are defined as actions, events or behaviors that place the participant at risk or describe a change in healthcare status.
• transfer to the emergency room
• unplanned transfer or discharge
• death

b. Complaints are defined as concerns expressed by participants, family members or others that indicate a perception that the participant is at risk.
• expressions of dissatisfaction with quality of services,
• expressions of dissatisfaction with types of services
• expressions of dissatisfaction with timeliness of services,
• communication issues

CDPH will maintain a reported event/complaint log of incidents, complaints and exceptional events/unusual occurrences.
CDPH and DHCS LTCD staff will analyze discovery findings for significance and determine the appropriate response.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The QAU 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 the DHCS/IHO Management Team. In evaluating performance that falls below the established standards, the QAU will determine the cause of the problem or lack of documentation through interviews with the DHCS RN 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 NF/AH Waiver requirements. The DHCS RN 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 IHO Management Team for the development of remedial actions.

The QAU 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 QAU Nurse Consultant, the DHCS/IHO Medical Consultant, DHCS RN Supervisors, and the DHCS RN who will be representing the DHCS at the State Fair Hearing. Lessons learned are shared with staff at the weekly DHCS/IHO Managers and Supervisors meeting and the weekly DHCS RN staff meetings. Information from these meetings can lead to process and procedure changes and/or updates to DHCS/IHO policies.

The DHCS/IHO Managers and Supervisors are responsible for conducting DHCS RN staff meetings. These meetings occur bi-weekly. The purpose of these meeting is to share information and provide training to the DHCS RNs. 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 DHCS policies, legislation that can affect the waiver participants, and results of QAU activities.

QAU conducts annual statewide meetings, as the budget permits, to provide training and updates to all DHCS/IHO staff. Based on areas of need identified by QAU reviews and requests by DHCS/IHO staff, the IHO Management Team locates speakers, identified by DHCS 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 QAU and a summary of identified issues, remedial actions and follow-up activities will be described in the annual CMS 373 Q report.

The QAU us responsible for generating cost reports using the participant's identification number and service identifiers for cost reports for HCBS and State Plan services. The QAU will also run cost reports on Medi-Cal beneficiaries who are receiving long term care in NF/AH Waiver facility alternatives. The results of these reports are analyzed by the QAU for trends and patterns across populations and reported to DHCS/IHO Branch Chief, Managers and Supervisors. Evidence of remedial actions will be described in the annual CMS 373 Q report.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The QAU will conduct a post-review evaluation of the review process and evaluation tools within 90 days after the Case Record Review and Provider Visit Review. 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. QAU will conduct a post-review of the implementation of the Provider Satisfaction Survey in 2012 and the Claims Quality Management Strategy in late 2012 or early in 2013. Changes to any of the above processes will be described in the annual CMS 373 Q report.

Appendix I: Financial Accountability

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).

HCBS 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).

Payments for waiver services are made through the approved California Medicaid Management Information System (CA-MMIS). The California Medicaid Management Information System (CA-MMIS) Division (previously FICOD) administers the Medi-Cal claiming system and manages the State's third party fiscal intermediary contract with Affiliated Computer Services (ACS).

Health Insurance and Portability and Accountability Act (HIPPA) Compliant HCPCS Codes are unique to each waiver service. Each provider type is only eligible to bill for the waiver services they render. The billing is via standardized billing forms and claims are submitted to ACS for payment. Only recognized Medi-Cal billers may be paid for waiver services.

All claims processed through ACS 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.

DHCS Audits & Investigations (A&I) Division is responsible for ensuring the fiscal integrity and medical necessity of Medi-Cal program services, including the NF/AH Waiver program. The Audits and Investigations Division conducts Medi-Cal claim reviews at least annually to determine if claims are processed correctly, if services were medically necessary, coded correctly and properly paid or denied. 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, Section 14124.2. A&I 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.

MRB staff work closely with Medi-Cal's fiscal intermediary 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. A&I IB is also responsible for coordinating provider fraud referrals to the California State Department of Justice (DOJ) and Federal Bureau of Investigation. Suspected fraud or abuse identified through any audit or investigation process is referred to the DOJ via the A&I IB.

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

Individual, unlicensed providers of Waiver Personal Care Services (WPCS) claims are paid through the California Department of Social Services (CDSS), In-Home Supportive Services (IHSS) program, Case Management Information Payrolling System (CMIPS), developed and managed by HP Enterprise Services. HP Enterprise Services will continue to oversee the CMIPS system and is currently launching CMIPS II which began it's phase-in plan on July 30, 2012.

DHCS examines the provider records and compares the records with the authorized services. If the received claim is correct, IHO Quality Assurance Unit (QAU) staff will authorize payment through CMIPS. QAU will contact A&I to conduct a more detailed financial analysis in the event of suspicious billing practices. The state conducts routine, random audits of all Medi-Cal, IHSS and WPCS billers to ensure competency and accuracy in the paid claims.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of MOHS that contained the same number of authorized waiver services, the same provider types and the same State Plan services as those described on the current POT.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of MOHS that contained the same number of waiver services and the same provider types as those authorized on the most recent TAR.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

		☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of MOHS that contained the same number of WPCS hours as those listed on the WPCS Authorization form and the CMIS Summary.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
	☐ **Weekly**	☐ **100% Review**

☑ **State Medicaid Agency**		
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of MOHS that were cost neutral to the Annual "G" Factor.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Percent of WPCS timesheets with the same hours approved for payment as those authorized on the WPCS authorization form in the case file.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
Percent of MOHS that were current with the date of the last home visit.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The DHCS QAU currently conducts ad hoc discovery activities based upon a provider's complaint of non-payment and the suspicion of fraud. The QAU will access either the Surveillance and Utilization Review Subsystem (SURS) or the CMIPS to obtain evidence that a claim was submitted by an HCBS NF/AH Waiver provider for prior authorization of NF/AH Waiver services and was reimbursed at the established rate for the service. The evidence is submitted to the DHCS IHO Management Team to determine what, if any, further action may be required. For issues concerning fraud, the QAU notifies A&I. For issues concerning non-payment for all but WPCS, the QAU, the DHCS RN, DHCS RN Supervisors, or Managers will assist the provider in resolving issues concerning the authorization of services. For issues beyond DHCS/IHO' ability to remedy, the provider will be referred to the ASI Help Desk. For non-payment of DHCS/IHO authorized WPCS services, the provider will be referred to the California Department of Social Services' IHSS program.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
DHCS IHO has contacted the DHCS Audit Coordinator and the process for an internal audit of NF/AH Waiver Claims by a State Agency other than IHO is scheduled for 2012. IHO proposes scheduling this type of an audit at least once during the life of the waiver.

DHCS/IHO will begin development of a Claims Quality Management strategy for reviewing NF/AH Waiver claims for allowability, allocability and accuracy of waiver services billed for purposes of claiming FFP. 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 MISDSS and CMIPS;

• Determine if the provider submitting the claim is a qualified NF/AH 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:
o Service Utilization Review Guidance and Evaluation (SURGE), or
o CMIPS

The QAU will conduct the review on a quarterly basis and provide the DHCS/IHO Management Team with the results within 10 days of the completion of the review. Based upon the results and the level of compliance, the DHCS/IHO Managers and Supervisors will develop and implement remediation activities within 30 days. Effectiveness of the remediation actions will be measured at the next quarterly review.

The timeline for this action is as follows:

1/1/12 – 3/31/12 – Conduct research on other claims discovery processes.

4/1/12 - 6/30/12 – 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.

7/1/12 - 9/30/12 – Make changes to the Claims Review Tool based upon the test. Determine the average number of NF/AH Waiver claims processed a year and determine a sample size of claims to be reviewed.

10/1/12 - 10/30/12 - Conduct a review on the representative sample of claims.

11/1/12 - 12/15/12 – Complete an analysis of the review and present recommendations to the DHCS/IHO Management Team.

1/2/13 – 3/1/13 – Develop and implement remediation actions as needed based upon the results of the review.

4/2013 – Implement the annual Claims Review

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

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).

Fee-For-Service(FFS)Rates Development Division is responsible for establishing the provider payment schedule for Medi-Cal services, developing and implementing systems to track and constrain the growth of Medi-Cal rates, and responding to rate-related inquiries from providers, associations, and other interested parties. FFS Rates Development formulates reimbursement methodologies for fee-for-service outpatient services and 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, FFS Rates Development Division 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.

6. 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.

DHCS/IHO uses three methods to establish rates for NF/AH Waiver services, which are based on provider type and the service provided:

• The adoption of published Medi-Cal provider rates found in the Current California Medi-Cal Fee Schedule published at:
http:://files.medi-cal.ca.gov/pubsdoco/rates/rates_download.asp.
or other State Department service rates for similar services;
• Hourly rates established locally by county governments/authorities; and,
• By report for prior authorized services, with minimum and maximum levels of payment described in the service description of Appendix C-1/C-2, Service Specifications.

Below is a description of the rate methodologies used to establish payment rates for NF/AH Waiver services.

RATE METHODOLOGY
Adoption of published provider rates found in the Current California Medi-Cal Fee Schedule published at:
http:://files.medi-cal.ca.gov/pubsdoco/rates/rates_download.asp.

The services listed below (Case Management, Family Training, Habilitation Services, Private Duty Nursing, and Respite) are based on the published provider rates paid to either a Registered Nurse (RN) employed by a Home Health Agency (HHA) or a RN that is an Individual Nurse Provider (INP), a Licensed Vocational Nurse (LVN) employed by a HHA or an LVN INP, or a Certified Home Health Aide (CHHA) employed by a HHA that provides intermittent private duty nursing.

Continuous Nursing and Supportive Services are based on the published provider rates paid to a Congregate Living Health Facility (CLHF) that were negotiated and agreed to in 2000.

The DD/CNC, non-ventilator dependent and the DD/CNC, ventilator dependent waiver services rates were determined by adding the cost of sufficient nursing hours to provide nursing care that corresponds to each of the two LOCs provided by an ICF/DD-CN waiver provider to the State Plan approved daily rate authorized for an ICF/DD-N facility. The ICF/DD-N rate is set by the DHCS FFS Rates Development Division. These facilities are grouped according to LOC and bed size. Providers for developmentally disabled consumers have rates set above the median as the result of a court settlement in 1990. The basis of this methodology is that these providers are disproportionate share providers that typically have higher than 95% Medi-Cal census. In the case of the waiver, the census is 100% Medi-Cal beneficiaries. The ICF/DD-CN waiver rates are published annually in the Medi-Cal Long Term Care Provider Manual. The effective date is August of each year. This rate methodology and published rates were

applicable to the DD/CNC Waiver, which is being incorporated into this renewal of the NF/AH Waiver.

HCBS SERVICE
• Case Management
• Family Training
• Habilitation Services
• Private Duty Nursing – RN, LVN, CHHA
• Respite
• Continuous Nursing and Supportive Services
• DD/CNC Non-Ventilator and Ventilator Dependent Services

RATE METHODOLOGY
Hourly rates established locally by county government/authorities that are negotiated between each individual county and its contractors, consistent with applicable regulation promulgated by the CDSS or the DHCS.

HCBS SERVICE
• Waiver Personal Care Services (WPCS)
• Respite (if provided by an unlicensed personal care provider)

RATE METHODOLOGY
By report for prior authorized services

HCBS SERVICE
• Environmental Accessibility Adaptations
• Personal Emergency Response (PERS) (activation and monthly service charge)
• Medical Equipment Operating Expense
• Community Transition Services

Environmental Accessibility Adaptations and Community Transitions: the provider overseeing the administration of the service submits all of the medical documentation and receipts for authorization and reimbursement. Both of these services are paid based on the receipts received for authorization up to the maximum allowable amount.

PERS and Medical Equipment Operating Expense: The provider overseeing the administration of the service submits the claim to reimburse the participant for life sustaining equipment utility costs or PERS services. Medical Equipment Operating Expenses are payable if over $20 up to a maximum of $75.

Rates paid for NF/AH Waiver services are published in the Medi-Cal Provider Manual and the Current California Medi-Cal Fee Schedule published at:
http:://files.medi-cal.ca.gov/pubsdoco/rates/rates_download.asp.
and notices of updates are sent to Medi-Cal providers by U.S. mail or by e-mail notices.

DHCS/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:

DHCS/IHO is responsible for prior authorization of all NF/AH Waiver services and verifies that the requested services are in accordance with the participant's Plan of Treatment (POT). NF/AH Waiver service providers are responsible for submitting a Treatment Authorization Request (TAR) to IHO for prior authorization of all NF/AH Waiver services except the WPCS benefit. The DHCS RN 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.

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

NF/AH Waiver providers submit claims to the Medi-Cal fiscal intermediary for services rendered using either a CMS 1500, UB 92 or UB 04 claim form. These claims are subject to all established requirements for processing directly through the CA-MMIS system. ACS adjudicates claims for services, resulting in one of four possible actions:

1. Paid (claim is paid);
2. Denied (claim is denied);
3. Suspended (Fiscal Intermediary 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. The Medi-Cal fiscal intermediary 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 by unlicensed individual care providers are paid through the California Department of Social Services (CDSS), In-Home Supportive Services (IHSS), Case Management Information Payrolling System (CMIPS), developed and managed by HP Enterprise Services.

The DHCS RN authorizes WPCS service hours by completing a written letter of authorization, that is forwarded to the waiver participant, the WPCS provider, and the DHCS/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 IHO Northern Region office for review and approval. The timesheets are reconciled with the hours authorized in accordance with the waiver participant's POT. 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.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government 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 Local Government Agencies.**

Specify: (a) the local government 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.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

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 service plan; and, (c) the services were provided:

DHCS/IHO is responsible for prior authorization of all NF/AH 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 NF/AH 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 DHCS/IHO negotiated rate;

• Participant was not institutionalized during the time covered by the claim; and

• Appropriate NF/AH 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 NF/AH Waiver program;

• Provider is enrolled as an IHSS provider authorized to provide services to the NF/AH 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 §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- ○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ◉ **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) and 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 when the service is provided by an individual, unlicensed caregiver.

  (b) WPCS provider time sheets are sent to the DHCS/IHO Northern Regional office in Sacramento. DHCS/IHO staff verifies eligibility for WPCS services, the county pay rate, and check the hours submitted for payment against hours authorized. DHCS/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 HP Enterprise Services 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) DHCS reimburses DSS for making payments for the authorized WPCS hours under the NF/AH Waiver. DSS provides DHCS 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:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☑ **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.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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:*

- ◉ **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; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. 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.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I -3-e.
- ○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. **Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government 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 State or local government providers differs from the amount paid to private providers of the same service. When a State or local government 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:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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:*

- ◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ○ **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.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ○ **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:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- ◉ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ○ **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.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

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. *Select at least one*:

- ☑ **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 State 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 State 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 State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government 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. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

  Specify: (a) the local government 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 local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

  Specify: (a) the source of funds; (b) the local government 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 local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

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: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

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:

In the HCBCCF CLHF and the ICF/DD-CN residences the waiver participant pays the facility/residence directly for the provision of room and board at the beginning of the month from his/her SSI/SSP income, retaining the Personal Needs Allowance as governed by regulation. The HCBCCF CLHF and ICF/DD-CN bill's the Medi-Cal program for the care rendered at the end of the month, only billing for the days in which the participant was enrolled in the NF/AH Waiver.

Appendix I: Financial Accountability

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:*

- ◉ **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.**
- ○ **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:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

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**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- ◉ **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; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Hospital, Nursing Facility, ICF/MR

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 Column4)
1	54933.15	27713.00	82646.15	131042.00	6447.00	137489.00	54842.85
2	54627.27	27713.00	82340.27	131042.00	6447.00	137489.00	55148.73
3	54393.07	27713.00	82106.07	131042.00	6447.00	137489.00	55382.93
4	54193.73	27713.00	81906.73	131042.00	6447.00	137489.00	55582.27
5	54046.43	27713.00	81759.43	131042.00	6447.00	137489.00	55729.57

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

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 Number Unduplicated Number of Participants (from Item B -3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care:	Level of Care:	Level of Care:
		Hospital	Nursing Facility	ICF/MR
Year 1	3276	300	2892	84
Year 2	3448	300	3052	96
Year 3	3620	300	3212	108
Year 4	3792	300	3372	120
Year 5	3964	300	3532	132

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

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-a.

The calculated average length of stay (ALOS) is 365

Assumptions used in calculation:

* NF/AH Waiver Enrollment experience shows that participants enrolled in the NF/AH Waiver will maintain continuous enrollment for their lifetime. The same is assumed for those individuals at the ICF/DD-CN levels of care.

* The ALOS is expected to remain constant each waiver year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

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 for existing waiver services are derived from experience as reported in the CMS 372 reorts for the NF/AH Waiver and estimates for utilization of infrequently used services. The CMS 372 Reports used:

WY 1 (January 1, 2007 - December 31, 2007)
WY 2 (January 1, 2008 - December 31, 2008)
WY 3 (January 1, 2009 - December 31, 2009)

The following are assumption also used in deriving the Factor D:

• 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. (Under certain circumstances described in Appendix C, the "lifetime" benefit cap may be waived.)

• Environment Accessibility Adaptations benefit is capped at a lifetime benefit of $5,000. (Under certain circumstances described in Appendix C, the "lifetime" benefit cap may be waived.)

• 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 a month with a maximum monthly amount of $75. For purposes of completing Appendix J-d, an average of $25 is used based on reported utilization obtained from CMS 372 reports.

• The average reimbursement rate for a waiver service is derived from averaging rates of reimbursement for the different providers providing a waiver service.

• The cost of waiver services is projected to remain static due to the current recession and budget constraints in California. DHCS/IHO does not anticipate any rate increases before 2016.

• Factor D utilization is based on the maximum number of unduplicated participants that can be served in any given waiver year. While in the past the actual number of unduplicated participants has been less than the maximum number allowed it is IHO's intention to eventually have NF/AH Waiver enrollment at capacity for each level of care.

• Factor D utilization for ICF/DD-CN Vent and Non-Vent Dependent LOC is based on the number of participants and their current services at the time of transition to the NF/AH Waiver as well as the assumption that any remaining slots will be filled during WY 1 with the majority of individuals at this LOC choosing to receive NF/AH Waiver services in the community rather than ICF/DD-CN facilities.

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 found in the NF/AH Waiver CMS 372 Reports for:

WY 1 (January 1, 2007 – December 31, 2007)
WY 2 (January 1, 2008 – December 31, 2008)
WY 3 (January 1, 2009 – December 31, 2009)

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 In Home Supportive Services (IHSS) program;

• Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services;

• 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'expenditures of individuals at the ICF/DD-CN Vent and Non-Vent Dependent LOC were weighted into the the Factor D' estimates for current NF/AH Waiver participants.

• There is no projected increase in these costs

• 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:

Factor G estimates are derived from the weighted daily facility rate for NF A, NF B, Pediatric NF B, NF-Distinct Part, Adult Subacute, Pediatric Subacute, ICF/DD-CN Non-Ventilator Dependent, ICF/DD-CN Ventilator Dependent and Acute hospital times 365 days a year.

Factor G reflects the peer group for participants in this waiver. The Factor G estimates for inpatient NF A, NF B, Pediatric NF B, NF-Distinct Part, Adult Subacute, Pediatric Subacute, ICF/DD-CN Non-Ventilator Dependent, ICF/DD-CN Ventilator Dependent and Acute hospital are derived from the State's daily institutional costs for 365 consecutive days.

Other assumptions used for obtaining Factor G are described below.

NF/AH Waiver CMS 372 reports for:

WY 1 (January 1, 2007 – December 31, 2007)
WY 2 (January 1, 2008 – December 31, 2008)
WY 3 (January 1, 2009 – December 31, 2009)

The Factor G (inpatient costs) is not projected to increase.

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 utilized during an inpatient NF A, NF B, Pediatric NF B, NF-Distinct Part, Adult Subacute, Pediatric Subacute, ICF/DD-CN Non-Ventilator Dependent, ICF/DD-CN Ventilator Dependent and Acute hospital stay as reported in CMS 372 reports for the NF/AH Waiver. The CMS 372 Reports used:

WY 1 (January 1, 2007 - December 31, 2007)
WY 2 (January 1, 2008 - December 31, 2008)
WY 3 (January 1, 2009 - December 31, 2009)

Factor G' is not projected to increase.

Medicare Part D drug costs are not included in the Factor G' estimates

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Case Management/Coordination	
Habilitation Services	
Home Respite	
Waiver Personal Care Services (WPCS)	
Community Transition Services	
Continuouse Nursing and Supportive Services	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	
Environmental Accessibility Adaptations	
Facility Respite	
Family/Caregiver Training	
Medical Equipment Operating Expense	
Personal Emergency Response (PERS) Installation and Testing	
Personal Emergency Response Systems (PERS)	
Private Duty Nursing - Including Home Health Aide and Shared Services	
Transitional Case Management	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management/Coordination Total:						**2261582.40**
Case Management/Coordination	Quarter Hour	2321	96.00	10.15	**2261582.40**	
Habilitation Services Total:						**9987.60**
Habilitation Services					**9987.60**	
				GRAND TOTAL:		**179960991.96**
				Total Estimated Unduplicated Participants:		**3276**
				Factor D (Divide total by number of participants):		**54933.15**
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Quarter Hour	12	82.00	10.15		
Home Respite Total:						**33033.60**
Home Respite	Quarter Hour	31	160.00	6.66	**33033.60**	
Waiver Personal Care Services (WPCS) Total:						**61267045.84**
Waiver Personal Care Services (WPCS)	Hours	2002	2546.00	12.02	**61267045.84**	
Community Transition Services Total:						**20000.00**
Community Transition Services	Event	4	1.00	5000.00	**20000.00**	
Continuouse Nursing and Supportive Services Total:						**8011713.50**
Continuouse Nursing and Supportive Services	Day	70	365.00	313.57	**8011713.50**	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						**4080094.10**
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	29	365.00	385.46	**4080094.10**	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						**2331912.00**
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	15	365.00	425.92	**2331912.00**	
Environmental Accessibility Adaptations Total:						**70000.00**
Environmental Accessibility Adaptations	Event	14	1.00	5000.00	**70000.00**	
Facility Respite Total:						**31357.00**
Facility Respite	Days	20	5.00	313.57	**31357.00**	
Family/Caregiver Training Total:						**30856.00**
Family/Caregiver Training	Hours	95	8.00	40.60	**30856.00**	
Medical Equipment Operating Expense Total:						**28500.00**
Medical Equipment Operating Expense	Months	95	12.00	25.00	**28500.00**	
Personal Emergency Response (PERS)						**210.00**

GRAND TOTAL:	**179960991.96**
Total Estimated Unduplicated Participants:	**3276**
Factor D (Divide total by number of participants):	**54933.15**
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Installation and Testing Total:						
Personal Emergency Response (PERS) Installation and Testing	Event	6	1.00	35.00	**210.00**	
Personal Emergency Response Systems (PERS) Total:						**8696.76**
Personal Emergency Response Systems (PERS)	Month	23	12.00	31.51	**8696.76**	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						**101770725.16**
RN	Hours	122	1480.00	36.26	**6547105.60**	
LVN	Hours	1101	3103.00	26.92	**91969568.76**	
CHHA	Hours	154	1118.00	18.90	**3254050.80**	
Transitional Case Management Total:						**5278.00**
Transitional Case Management	Hours	5	26.00	40.60	**5278.00**	
				GRAND TOTAL:		**179960991.96**
				Total Estimated Unduplicated Participants:		**3276**
				Factor D (Divide total by number of participants):		**54933.15**
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management/Coordination Total:						**2379484.80**
Case Management/Coordination	Quarter Hour	2442	96.00	10.15	**2379484.80**	
Habilitation Services Total:						**10819.90**
Habilitation Services	Quarter Hour	13	82.00	10.15	**10819.90**	
				GRAND TOTAL:		**188354829.05**
				Total Estimated Unduplicated Participants:		**3448**
				Factor D (Divide total by number of participants):		**54627.27**
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Respite Total:						**31204.80**
Home Respite	Quarter Hour	33	160.00	5.91	**31204.80**	
Waiver Personal Care Services (WPCS) Total:						**64908793.32**
Waiver Personal Care Services (WPCS)	Hour	2121	2546.00	12.02	**64908793.32**	
Community Transition Services Total:						**20000.00**
Community Transition Services	Event	4	1.00	5000.00	**20000.00**	
Continuouse Nursing and Supportive Services Total:						**8240619.60**
Continuouse Nursing and Supportive Services	Day	72	365.00	313.57	**8240619.60**	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						**4080094.10**
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	29	365.00	385.46	**4080094.10**	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						**2331912.00**
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	15	365.00	425.92	**2331912.00**	
Environmental Accessibility Adaptations Total:						**75000.00**
Environmental Accessibility Adaptations	Event	15	1.00	5000.00	**75000.00**	
Facility Respite Total:						**32924.85**
Facility Respite	Days	21	5.00	313.57	**32924.85**	
Family/Caregiver Training Total:						**32480.00**
Family/Caregiver Training	Hours	100	8.00	40.60	**32480.00**	
Medical Equipment Operating Expense Total:						**29700.00**
Medical Equipment Operating Expense	Months	99	12.00	25.00	**29700.00**	
Personal Emergency Response (PERS) Installation and Testing Total:						**210.00**

GRAND TOTAL:	**188354829.05**
Total Estimated Unduplicated Participants:	**3448**
Factor D (Divide total by number of participants):	**54627.27**
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response (PERS) Installation and Testing	Event	6	1.00	35.00	210.00	
Personal Emergency Response Systems (PERS) Total:						9074.88
Personal Emergency Response Systems (PERS)	Months	24	12.00	31.51	9074.88	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						106163010.40
RN	Hours	126	1480.00	36.26	6761764.80	
LVN	Hours	1150	3103.00	26.92	96062674.00	
CHHA	Hours	158	1118.00	18.90	3338571.60	
Transitional Case Management Total:						9500.40
Transitional Case Management	Hour	9	26.00	40.60	9500.40	
				GRAND TOTAL:		188354829.05
				Total Estimated Unduplicated Participants:		3448
				Factor D (Divide total by number of participants):		54627.27
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management/Coordination Total:						2492515.20
Case Management/Coordination	Quarter Hour	2558	96.00	10.15	2492515.20	
Habilitation Services Total:						10819.90
Habilitation Services	Quarter Hour	13	82.00	10.15	10819.90	
Home Respite Total:						32150.40
				GRAND TOTAL:		196902930.11
				Total Estimated Unduplicated Participants:		3620
				Factor D (Divide total by number of participants):		54393.07
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Respite	Quarter Hour	34	160.00	5.91	32150.40	
Waiver Personal Care Services (WPCS) Total:						68581143.72
Waiver Personal Care Services (WPCS)	Hour	2241	2546.00	12.02	68581143.72	
Community Transition Services Total:						20000.00
Community Transition Services	Event	4	1.00	5000.00	20000.00	
Continuouse Nursing and Supportive Services Total:						8469525.70
Continuouse Nursing and Supportive Services	Day	74	365.00	313.57	8469525.70	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						4080094.10
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	29	365.00	385.46	4080094.10	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						2331912.00
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	15	365.00	425.92	2331912.00	
Environmental Accessibility Adaptations Total:						85000.00
Environmental Accessibility Adaptations	Event	17	1.00	5000.00	85000.00	
Facility Respite Total:						32924.85
Facility Respite	Days	21	5.00	313.57	32924.85	
Family/Caregiver Training Total:						34104.00
Family/Caregiver Training	Hours	105	8.00	40.60	34104.00	
Medical Equipment Operating Expense Total:						31500.00
Medical Equipment Operating Expense	Months	105	12.00	25.00	31500.00	
Personal Emergency Response (PERS) Installation and Testing Total:						210.00

GRAND TOTAL:	196902930.11
Total Estimated Unduplicated Participants:	3620
Factor D (Divide total by number of participants):	54393.07
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response (PERS) Installation and Testing	Event	6	1.00	35.00	210.00	
Personal Emergency Response Systems (PERS) Total:						9453.00
Personal Emergency Response Systems (PERS)	Months	25	12.00	31.51	9453.00	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						110682076.84
RN	Hours	130	1480.00	36.26	6976424.00	
LVN	Hours	1199	3103.00	26.92	100155779.24	
CHHA	Hours	168	1118.00	18.90	3549873.60	
Transitional Case Management Total:						9500.40
Transitional Case Management	Hours	9	26.00	40.60	9500.40	
				GRAND TOTAL:		196902930.11
				Total Estimated Unduplicated Participants:		3620
				Factor D (Divide total by number of participants):		54393.07
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management/Coordination Total:						2605545.60
Case Management/Coordination	Quarter Hour	2674	96.00	10.15	2605545.60	
Habilitation Services Total:						11652.20
Habilitation Services	Quarter Hour	14	82.00	10.15	11652.20	
Home Respite Total:						34041.60
				GRAND TOTAL:		205502620.05
				Total Estimated Unduplicated Participants:		3792
				Factor D (Divide total by number of participants):		54193.73
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Respite	Quarter Hour	36	160.00	5.91	**34041.60**	
Waiver Personal Care Services (WPCS) Total:						**72253494.12**
Waiver Personal Care Services (WPCS)	Hour	2361	2546.00	12.02	**72253494.12**	
Community Transition Services Total:						**25000.00**
Community Transition Services	Event	5	1.00	5000.00	**25000.00**	
Continuouse Nursing and Supportive Services Total:						**8698431.80**
Continuouse Nursing and Supportive Services	Day	76	365.00	313.57	**8698431.80**	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						**4080094.10**
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	29	365.00	385.46	**4080094.10**	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						**2331912.00**
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	15	365.00	425.92	**2331912.00**	
Environmental Accessibility Adaptations Total:						**95000.00**
Environmental Accessibility Adaptations	Event	19	1.00	5000.00	**95000.00**	
Facility Respite Total:						**36060.55**
Facility Respite	Days	23	5.00	313.57	**36060.55**	
Family/Caregiver Training Total:						**36052.80**
Family/Caregiver Training	Hours	111	8.00	40.60	**36052.80**	
Medical Equipment Operating Expense Total:						**33000.00**
Medical Equipment Operating Expense	Months	110	12.00	25.00	**33000.00**	
Personal Emergency Response (PERS) Installation and Testing Total:						**210.00**

GRAND TOTAL:	**205502620.05**
Total Estimated Unduplicated Participants:	**3792**
Factor D (Divide total by number of participants):	**54193.73**
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response (PERS) Installation and Testing	Event	6	1.00	35.00	**210.00**	
Personal Emergency Response Systems (PERS) Total:						**10209.24**
Personal Emergency Response Systems (PERS)	Months	27	12.00	31.51	**10209.24**	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						**115242415.64**
RN	Hours	134	1480.00	36.26	**7191083.20**	
LVN	Hours	1249	3103.00	26.92	**104332417.24**	
CHHA	Hours	176	1118.00	18.90	**3718915.20**	
Transitional Case Management Total:						**9500.40**
Transitional Case Management	Hours	9	26.00	40.60	**9500.40**	
				GRAND TOTAL:		**205502620.05**
				Total Estimated Unduplicated Participants:		**3792**
				Factor D (Divide total by number of participants):		**54193.73**
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management/Coordination Total:						**2754628.80**
Case Management/Coordination	Quarter Hour	2827	96.00	10.15	**2754628.80**	
Habilitation Services Total:						**12484.50**
Habilitation Services	Quarter Hour	15	82.00	10.15	**12484.50**	
Home Respite Total:						**34987.20**
				GRAND TOTAL:		**214240056.22**
				Total Estimated Unduplicated Participants:		**3964**
				Factor D (Divide total by number of participants):		**54046.43**
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Respite	Quarter Hour	37	160.00	5.91	34987.20	
Waiver Personal Care Services (WPCS) Total:						75925844.52
Waiver Personal Care Services (WPCS)	Hour	2481	2546.00	12.02	75925844.52	
Community Transition Services Total:						25000.00
Community Transition Services	Event	5	1.00	5000.00	25000.00	
Continuouse Nursing and Supportive Services Total:						8927337.90
Continuouse Nursing and Supportive Services	Day	78	365.00	313.57	8927337.90	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						4080094.10
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	29	365.00	385.46	4080094.10	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						2331912.00
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	15	365.00	425.92	2331912.00	
Environmental Accessibility Adaptations Total:						105000.00
Environmental Accessibility Adaptations	Event	21	1.00	5000.00	105000.00	
Facility Respite Total:						37628.40
Facility Respite	Days	24	5.00	313.57	37628.40	
Family/Caregiver Training Total:						38001.60
Family/Caregiver Training	Hours	117	8.00	40.60	38001.60	
Medical Equipment Operating Expense Total:						34500.00
Medical Equipment Operating Expense	Months	115	12.00	25.00	34500.00	
Personal Emergency Response (PERS) Installation and Testing Total:						35000.00

GRAND TOTAL:	214240056.22
Total Estimated Unduplicated Participants:	3964
Factor D (Divide total by number of participants):	54046.43
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response (PERS) Installation and Testing	Event	7	1.00	5000.00	**35000.00**	
Personal Emergency Response Systems (PERS) Total:						**10587.36**
Personal Emergency Response Systems (PERS)	Months	28	12.00	31.51	**10587.36**	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						**119877549.44**
RN	Hours	139	1480.00	36.26	**7459407.20**	
LVN	Hours	1299	3103.00	26.92	**108509055.24**	
CHHA	Hours	185	1118.00	18.90	**3909087.00**	
Transitional Case Management Total:						**9500.40**
Transitional Case Management	Hours	9	26.00	40.60	**9500.40**	

GRAND TOTAL:	**214240056.22**
Total Estimated Unduplicated Participants:	**3964**
Factor D (Divide total by number of participants):	**54046.43**
Average Length of Stay on the Waiver:	365