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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
The following are updates that have been made to the waiver renewal:•

• Contracting with local care management agencies
• Increasing overall waiver capacity
• Removing the individual cost limit and moving to an aggregate cost neutrality, with service approval being based on medical necessity
• Integrating the In-Home Operations (IHO) Waiver population
• Changing the name of the Nursing Facility/Acute Hospital (NF/AH) Waiver to Home and Community-Based (HCB) Alternatives Waiver.
• Updating participant rights
• Including the HCB Settings transition plan to align with the Statewide Transition Plan.
• Consolidating the Levels of Care (LOC)
• Removing Treatment Authorization Requests (TAR) to the Department of Health Care Services (DHCS)
• Changing to a weighted average cost across the LOCs (derivation of estimates)
• Updating the rate methodologies
• Including Overtime and Travel Time updates in compliance with the Fair Labor Standards Act (FLSA)

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*):
Home and Community Based Alternatives Waiver

C. Type of Request: renewal

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.R05.00
Draft ID: CA.016.05.00

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

Regular Waiver

E. Proposed Effective Date: *(mm/dd/yy)*

01/01/17

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*):

- [x] **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**

- [x] **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**

- [x] **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
  If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID 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:

☐ **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 Home and Community-Based Alternatives, hereafter referred to as the HCB Alternatives Waiver, is to provide Medi-Cal members 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 members from a medical facility to his/her home or community setting utilizing HCB Alternatives Waiver services; 2) offer Medi-Cal eligible members who reside in the community but are at risk of being institutionalized within the next 30 days, the option of utilizing HCB Alternatives Waiver services to develop a home or community setting program that will safely meet his/her medical care needs; 3) maintain overall cost neutrality.

The Department of Health Care Services (DHCS), Long-Term Care Division (LTCD) is responsible for monitoring the HCB Alternatives Waiver. Organizationally, DHCS LTCD has two regional offices. The northern and southern California regional offices are responsible for reviewing and approving initial waiver LOC determinations, changes in LOC redeterminations and ongoing monitoring and oversight of local Care Management Agencies (CMAs) who administer the waiver and perform 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 current primary care physician or designated physician assistant or nurse practitioner (herein referred to as "participant's current primary care physician") and all HCBS waiver providers. The POT describes all the participant's medically necessary waiver care services, frequency and providers of the identified services to ensure his/her health and safety are maintained in a home or community setting. In signing the POT, the participant's current primary care physician is attesting to the medical necessity of the waiver services identified in the POT.

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; CMA staff will carry out LOC determinations and redeterminations; and DHCS will continue approving LOC determinations and changes through redeterminations.

CMAs assist waiver participants with location of appropriate HCB settings, development of a person-centered care plan, identification of available waiver providers, and continuous care management of waiver and other Medicaid services. Appropriate home and community-based settings include the participant's private home and congregate living health facilities (CLHFs). A participant's person-centered care plan includes the Intake Medical Summary (IMS), Case Management Report (CMR), POT, Menu of Health Services (MOHS), and Informing Notice which creates the Case Report or File. 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.

The Care Management Team (CMT) consists of a Registered Nurse (RN) and a Master of Social Work (MSW) employed with a contracted Care Management Agency (CMA). In areas where a CMA is not available, the CMT consists of a DHCS employed RN and an HCB Care Management Waiver Provider, if applicable. The CMT provides ongoing care management and works with the participant to identify and coordinate State Plan and waiver services, and other resources necessary to enable the participant to transition to the community or to remain in his/her home.

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/IID.

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:
In October 2015, DHCS held two public meetings/phone conferences to discuss the NF/AH Waiver Renewal. DHCS conducted participant and family member interviews. An open invitation was posted on the NF/AH Waiver Renewal website to allow all waiver participants, advocates, providers of waiver services, and any other interested party, to provide public comment on the renewal of the NF/AH Waiver. An invitation was also mailed to all active participants and providers inviting them to attend, either in person or by telephone, or to submit any questions or comments directly to DHCS by mail, email or telephone.

DHCS formed a technical workgroup comprised of NF/AH Waiver members, family members, advocates, providers and other interested stakeholders for guiding and recommending the proposal of the NF/AH Waiver Renewal application. The workgroup collaborated and guided DHCS on the development of the waiver renewal application to best serve and meet the needs of the waiver population. The workgroup met on December 18, 2015, February 18, 2016, and April 20, 2016.

The draft NF/AH Waiver, proposed to be renamed as HCB Alternatives Waiver, renewal proposal was posted on the DHCS NF/AH Waiver Renewal webpage at: http://www.dhcs.ca.gov/services/ltc/Pages/Nursing-Family-Acute-Hospital-(NF--AH)-Waiver-Renewal.aspx and sent to the California Legislative staff and Disability Rights California. Written public comments were accepted from June 10, 2016 through 5:00 pm on July 10, 2016.

DHCS held five stakeholder meetings throughout the state (July 7, 2016, Sacramento; July 14, 2016 Fresno; July 18, 2016, Los Angeles; July 19, 2016, San Diego, and July 29, 2016, Redding) to discuss the comments received on the waiver renewal during the 30-day public comment period, and to inform the public of changes made to the waiver

application as a result of the public input received. A summary of comments received and DHCS' response(s) is available on the DHCS NF/AH Waiver Renewal webpage listed above (hard copies were mailed to waiver participants/providers upon request.

Along with the public input obtained at the public stakeholder meetings and Olmstead meetings, DHCS also receives ongoing public input and strives to act on that input in a proactive manner as circumstances allow.

DHCS continues to hold meetings and engage with community based organizations that perform care management activities, as well as the Care Coordination Agencies (CCA) and Lead Organizations (LO) regarding the waiver renewal and upcoming changes.

DHCS provided copies of the waiver application to persons who requested copies, prior to submission to CMS.

Please see the following link for the summary of public comment and DHCS responses.
http://www.dhcs.ca.gov/services/ltc/Pages/Nursing-Family-Acute-Hospital-(NF--AH)-Waiver-Renewal.aspx

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:	Schupp
First Name:	Rebecca
Title:	Chief, Long-Term Care Division
Agency:	Department of Health Care Services
Address:	1501 Capitol Avenue
Address 2:	PO Box 997413, MS 0000
City:	Sacramento
State:	**California**
Zip:	95899-7413
Phone:	(916) 319-9247 **Ext:** ☐ ☐ **TTY**
Fax:	(916) 552-9660
E-mail:	rebecca.schupp@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 Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Cantwell

First Name: Mari

Title: State Medicaid Director

Agency: Department of Health Care Services

Address:

	1501 Capitol Avenue, Ste. 6000
Address 2:	PO Box 997413 MS 0000
City:	Sacramento
State:	**California**
Zip:	95899-7413
Phone:	(916) 440-7400 **Ext:** ☐ ☐ **TTY**
Fax:	(916) 440-7404
E-mail:	mari.cantwell@dhcs.ca.gov

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☑ **Replacing an approved waiver with this waiver.**
- ☑ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☑ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☑ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☑ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

1. Prospective HCB Alternatives Waiver participants who are currently enrolled in the IHO Waiver will be given a 30-day 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 HCB Alternatives Waiver or institutionalization in a nursing facility, subacute facility, or acute care facility.

2. Current IHO Waiver participants who choose to transition to the HCB Alternatives Waiver will receive a Freedom of Choice (FOC) document. The Freedom of Choice document will be signed by the participant prior to the expiration of the current IHO Waiver. This process will be expedited with the assistance of the CMT. All current IHO Waiver participants choosing transition to the HCB Alternatives Waiver will be administratively placed into the HCB Alternatives Waiver with no material change to their eligibility or scope of service(s).

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to

this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Medically necessary HCB Alternatives Waiver services are delivered in the private dwellings of the Participants. The State therefore presumes that these dwellings meet the characteristics of home and community-based residential settings.

HOME AND COMMUNITY-BASED SETTINGS TRANSTION PLAN:

California assures that the settings transition plan included with this renewal will be subject to any provisions or requirements included in California's approved Statewide Transition Plan. California will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

STATEWIDE TRANSITION PLAN REGARDING THE HCB ALTERNATIVES WAIVER:

The HCB Alternatives Waiver provides care management services to frail persons at risk for nursing home or institutional placement. The care management services are provided by a multidisciplinary care team comprised of a nurse and social worker. The care management team coordinates State Plan services (e.g., medical, behavioral health and In-Home Supportive Services), arranges for other long-term services and supports and, in some instances, purchases items or services that augment existing State Plan services. Care management occurs in the Participant's personal home. This home setting can be a privately owned residence, a tenant lease arrangement, or the residence of a Participant's family.

HCB ALTERNATIVES WAIVER PROVIDER TYPES INCLUDE THE FOLLOWING:

• Associate Clinical Social Worker (ACSW)
• Behavioral Therapist
• Durable Medical Equipment Provider
• Employment Agency
• Congregate Living Health Facility
• Home Health Agency
• Home Health Aide
• In-Home Supportive Services Public Authority
• Intermediate Care Facility for the Developmentally Disabled – Continuous Nursing Care
• Licensed Clinical Social Worker
• Licensed Psychologist
• Licensed Vocational Nurse
• Marriage Family Therapist
• Non-Profit or Proprietary Agency
• Personal Care Agency
• Private Nonprofit or Proprietary Agency
• Professional Corporation
• Registered Nurse
• Waiver Personal Care Services Provider

THE COMPLIANCE DETERMINATION PROCESS INCLUDES ALL OF THE FOLLOWING:

For settings presumed not to be HCB settings, pursuant to CMS regulations, evidence will be provided to CMS for application of the heightened scrutiny process. Such settings will be identified through the review of state laws and regulations, provider and beneficiary self-surveys, existing monitoring and oversight processes and stakeholder input throughout the transition process.

• For all other settings, a sample of on-site assessments will be conducted. The sample results will be used to inform the stakeholder process as changes are made to the system to ensure monitoring and ongoing compliance through standard processes, such as licensing and/or certification. The sample results will also be used to guide the process of bringing HCB

settings into compliance.
• The State departments have developed an agency-wide core On-Site Assessment Tool, for use in the on-site assessments of HCB settings. The core assessment tool includes questions that relate to each new federal requirement that will be used to determine if the HCB setting meets or does not meet the required federal rule. The State departments have also developed an agency-wide core Provider Self-Survey Tool, which will be forwarded to all HCB settings for completion. The results of these provider self-surveys will be reviewed by the appropriate State department/entity administering the program, and may trigger on-site assessments when indicators of non-compliance are identified.
• In addition to the core On-Site Assessment Tools and Provider Self-Survey Tools, the State departments, in collaboration with advocacy organizations, are developing core Beneficiary Self-Survey Tools, which will be distributed by the appropriate State department/entity administering the program to Participants throughout the State.
• The written results of each on-site assessment will be forwarded back to the HCB setting with specific information regarding improvements that will be required in order for the setting to come into compliance with the federal requirements and a timeline for completion. Follow up of the compliance issues will be the responsibility of the administering State department/entity.
• The outcome of the on-site assessments will be reported by each requirement and each HCB site where an on-site assessment was conducted. Remedial actions will be developed to include timelines, milestones and a description of the monitoring process to ensure timelines and milestones are met.

All State-level and individual-setting level remedial actions will be completed no later than March 17, 2019.

The State will ensure that HCB settings remain in compliance with the new requirements by utilizing current ongoing licensing and/or certification processes for both residential and non-residential settings, as well as weaving compliance reviews into current monitoring and oversight processes.

STAKEHOLDER INPUT:

The State conducted two public comment periods and received comments from NF/AH Participants, stakeholder and advocacy networks. Below is a summary of the most common stakeholder input:
California HCBS Requirements must not become stricter than federal regulations.

Add language relative to parental or guardian choice of services/settings for children. STP does not specify Plan for children under 18 years of age; therefore, the STP assumes children's needs are the same as adults.

STP states California does not anticipate relocation of consumers, but gated communities and ICF-DDs are presumed not to have the qualities of HCBS. California must take steps to increase availability of services in integrated settings and have these options available if/when consumers are transitioned.

California should reject new applications for clustered and congregate projects, gated communities, and Intermediate Care Facilities, and should stop placing consumers in these settings.

Suggest language to be added to the background sections of the Waivers.

Please do not make sweeping restrictions that rule out options for many whom would be well served by them. Decisions about what is community-based should be made based on what actually happens in an environment and how well that fits with the needs of the residents, not based on some description of the housing and its address.

Any implementation of the HCBS waiver program should include the following:

• Maximum ability for the disabled person to be supported in the setting of his/her choice and, if unable to make such a choice, the choice loved ones determine is best.
• A range of options must be included so that we are not trying to create a "one size fits all" environment where outsiders are judging where a disabled individual belongs.
• A high quality of life is essential to each individual and should be the criteria for assessment of a setting, not where housing is located, nor the size of a particular setting, nor who the disabled person wants to live with, nor proximity to any particular amenities.
• People with developmental disabilities, or those who love them, should not have to be afraid of losing critical support services for choosing or developing their desired home, work and community opportunities.
• A least restrictive environment for one person may not be the least restrictive environment for another with different support needs, social needs, or interests. This difference should be respected and supported.
• California must not limit desired support services, employment, or housing choices for people with developmental

disabilities, but should instead be helping to expand and fund creative solutions to address this enormous need.
• No two people with developmental disabilities are exactly alike and therefore no single setting or preference should receive priority for HCBS funding over another.

Please do not use the HCBS Waiver Program as a means of limiting our children's choices for living the lives they want, in an environment of their choosing, and creating a meaningful future for themselves. Please do not limit their rights.

SYSTEMIC ASSESSMENT:

Provider Setting Type - Congregate Living Health Facility

HCBS Setting Requirement # Requirement Met, Partially Met, Conflicting, Silent
Remedial Strategy
Timeline for Completion

1 Met
H & S Section 1250

Waiver Language:
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

None
Not Applicable

2 Met
H & S Section 1267.13
22 CCR Section 51344

Waiver Language:
Common areas in addition to the space allotted for the resident's sleeping quarters, shall be provided in sufficient quantity to promote the socialization and recreational activities of the residents in a homelike communal manner

None
Not Applicable

3 Met
H & S Section 12657.7

Waiver Language:
Bathrooms of sufficient space and quality shall be provided to allow for 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.

Partially met
H & S Section 1267.13. (j)
DHCS will modify Waiver language to include the requirement that consumer to bathroom ratios promote the right to privacy, dignity and respect.
January 2017

4 Met
H & S Section 1250 (i) (5)
H & S Section 1267.13 (d)

Waiver Language:
Common areas in addition to the space allotted for the resident's sleeping quarters, shall be provided in sufficient quantity to promote the socialization and recreational activities of the residents in a homelike and communal manner.

None
Not Applicable

5 Met
22 CCR Section 51343.2

Waiver Language:
As a Waiver service provider, each HCB Alternatives 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 medically necessary services will be provided, the frequency of the services and identified 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
• 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.

None
Not Applicable

6 All CLHF residents sign a legally enforceable lease agreement with the residential setting provider, however Health and Safety Code is silent on this protocol.

DHCS will modify Waiver language to require that a legally enforceable lease agreement exists between provider and consumer
January 2017

7 Met
H & S Section 1267.13

The facility shall be 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.

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.
None
Not Applicable

8 Silent

DHCS will modify Waiver language to include the requirement that consumer may control their own schedules including access to food.
January 2017

9 Met
H & S Section 1267.13

None
Not Applicable

10 Met
H & S Section 1267.13

None
Not Applicable

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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:
   Long-Term Care Division
   (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.:*
     Following State contracting requirements, DHCS contracts with CMAs to administer the program locally. These local CMAs represent a wide variety of service delivery agencies and geographic areas with diverse Waiver Participant populations. Other than the direct provision of care management services, CMA staff purchase the Waiver Services through subcontracts with local vendors.

     Care Management involves the coordination and usage of existing community resources which provide the services required, enabling Waiver Participants to continue living at home. HCB Alternatives care management provides for Waiver Participant assessment, care planning, service arrangement and Waiver Participant and service provider monitoring. The CMT provides each Waiver Participant with a complete health and psychosocial assessment to determine the service(s) needed. The CMT then works with the Waiver Participant, family and/or care givers to develop an individualized care plan. To arrange for services, the CMA first explores informal support that might be available through family, friends and the voluntary community. The CMA then reviews existing publicly funded services and makes direct referrals whenever possible. If needed services are not available through friends, family and other programs, the CMT can authorize the purchase of medically necessary waiver services with program funds.
   - ( ) **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:

    DHCS may, at its discretion, contract with local public agencies to perform waiver operational and administrative activities/functions. These entities must meet DHCS' performance standards and requirements, including the demonstrated organizational, administrative and financial capabilities to carry out the contractual responsibilities of the waiver.
  - ☐ **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:

    DHCS may, at its discretion, contract with local non-governmental non-state agencies to perform waiver operational and administrative activities/functions. These entities must meet DHCS' performance standards and requirements, including the demonstrated organizational, administrative and financial capabilities to carry out the contractual responsibilities of the waiver.

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:
   State Medicaid Agency

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:
   DHCS shall monitor CMA performance at least every 24 months through onsite Quality Assurance Reviews (QAR) of: Waiver Participant records, progress notes, assessments, re-assessments, screening documents, timeliness of action, Waiver Participant plans of care, documentation of the audit trail, verification of service delivery, Waiver Participant satisfaction and any other pertinent documentation. Noncompliance with waiver and program standards can result in a plan of correction, technical assistance and financial and/or enrollment sanctions. When corrective action is required, the CMA responds with a formal Corrective Action Plan (CAP) to address any deficiencies. Upon initial approval of the CAP, DHCS monitors the CMAs resolution process to ensure complete remediation of the deficiency(ies). DHCS may, at its discretion, conduct an on-site follow-up visit to the CMA to evaluate the effectiveness of the new practice(s), and/or request submission of records for additional review by DHCS. The CMA does not receive a CAP approval letter until complete resolution has been verified by DHCS. Technical assistance is provided throughout the process on an as needed basis.

DHCS provides ongoing technical assistance to CMAs and requires quarterly reports from each CMA that include updates on enrollment levels, fiscal performance and quality assurance activities. DHCS communicates regularly via telephone, email and periodic meetings with CMAs.

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	Contracted Entity	Local Non-State Entity
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 the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver

- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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:
#/% of executed contracts between the Medicaid agency and local/regional non-state agencies. Numerator - Number of executed contracts/Denominator - Number of request for application documents

Data Source (Select one):
Other
If 'Other' is selected, specify:
Executed contracts and Request for Applications

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.

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 DHCS will provide technical assistance or training which may include, but is not limited to, clarifying waiver requirements, policies and procedures or standards of participation. On a continuous and ongoing basis DHCS may provide technical assistance, request and require an action plan, as applicable, revision of policies and procedures when necessary, and conduct individual, case by case, follow-up, with the CMA on specific issues to assure the resolution of problems/discrepancies in a timely manner.

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

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 one or more groups 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 or more waiver target groups, check each of the subgroups in the selected target group(s) 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		☑
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

California uses the State's definition of "developmentally disabled" and "substantial disability" for the target population of this waiver, as defined in the California Lanterman Developmental Disabilities Services Act, Welfare and Institutions Code, §4512, as follows:

"Developmental disability" means a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include disabling conditions found to be closely related to mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.

"Substantial disability" means the existence of significant functional limitations in three or more of the following areas of
major life activity, as determined by a regional center, and as appropriate to the age of the person:
(1) Self-care.
(2) Receptive and expressive language.
(3) Learning.
(4) Mobility.
(5) Self-direction.
(6) Capacity for independent living.
(7) Economic self-sufficiency.

• Regional center consumers who are Medi-Cal members who meet the level of care for this waiver.

• Consumers shall only be enrolled in one Section1915(c) waiver at any one time.

Acute Hospital LOC General Definition:

Participants to be served under this waiver at the acute 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.

Subacute LOC General Definition:

Participants to be served under this waiver at the subacute LOC must be currently receiving medically necessary subacute LOC services and in lieu of remaining in, or being admitted to the subacute setting, are choosing to remain at home or transition home and continue to receive medically necessary subacute LOC services as a participant enrolled in the waiver.

NF-A/B LOC General Definition:

Participants to be served under this waiver at the NF-A/B LOC must be currently receiving medically necessary NF-A/B LOC services and in lieu of remaining in, or being admitted to the NF-A/B setting, are choosing to remain at home or transition home and continue to receive medically necessary NF-A/B LOC services as a participant enrolled in the waiver.

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.

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

- ( ) **The following dollar amount:**

  Specify dollar amount:

  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)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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:

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:

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	8964
Year 2	8964
Year 3	8964
Year 4	8964
Year 5	8964

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	4174
Year 2	5174
Year 3	6174
Year 4	7174
Year 5	8174

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
Individuals Residing in a Facility and Individuals Transitioning from EPSDT or Similar Programs

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 and Individuals Transitioning from EPSDT or Similar Programs

Purpose *(describe):*

HCB Alternatives Waiver reserves 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 HCB Alternatives through California Community Transitions (CCT). 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, to find services and supports that could help them live in a community setting.

"Individuals Transitioning from EPSDT or Similar Programs"

Purpose (describe):

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

Describe how the amount of reserved capacity was determined:

The reserve capacity is set based on the enrollment requirement of 60 percent of total enrollments and historical transition counts from institutions and EPSDT or similar programs.

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

Waiver Year	Capacity Reserved
Year 1	600
Year 2	600
Year 3	600
Year 4	600
Year 5	600

Appendix B: Participant Access and Eligibility

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

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 HCB Alternatives Waiver will increase up to capacity as described in Appendix B-3: a through c.

Enrollment is based upon a blend of 60 percent institutional and EPSDT, or similar program, transitioned individuals and 40 percent of individuals at risk of institutionalization.

An individual requesting HCB Alternatives Waiver services must complete and submit a HCBS Waiver Application to the CMA or DHCS. 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. The CMT will identify the applicant's potential LOC based on the information provided on the application. If a waiver slot is available the CMT 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 HCB Alternatives Waiver. If there are no waiver slots available, applicants who potentially meet the waiver's LOC criteria, will be placed on the waitlist. The CMT will then send a letter confirming receipt of the completed HCBS Waiver Application which will include the effective date of placement on the HCB Alternatives Waiver waitlist.

The CMA will consider a potential waiver participant requesting HCB Alternatives Waiver services to be provided while residing in an ICF/DD-CN residence based on selection through the coordinated efforts of the Department of Developmental Services regional centers and the waiver providers. Before the CMA 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 HCB Alternatives 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, the CMA s will establish and maintain their own waitlist of individuals eligible for potential enrollment in the HCB Alternatives Waiver. Waiver slots that become available due to the death of a participant will be filled with a new participant from the appropriate waitlist.

Within 60 days of notification of an available waiver slot, an individual must schedule a face-to-face evaluation with the CMT 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 HCB Alternatives Waiver, the participant must identify a waiver service provider and provide the CMT with the participant's current primary care physician-signed POT that meets the requirements outlined in Appendix D. In signing the POT, the participant's current primary care physician is attesting to the medical necessity of the waiver services identified in the POT. If a participant's current 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 a CMA or DHCS at any time.

The 90-day time period will be extended only for individuals who have applied for Medi-Cal where special rules, such as institutional deeming and spousal impoverishment, are being applied to determine their Medi-Cal eligibility

because of their pending enrollment in the HCB Alternatives 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.

Available waiver slots will be assigned to HCB Alternatives Waiver eligible individuals who are on the waitlist in the following order:

1. Individuals who have been residing in a health care facility for at least 90 days and individuals aging out of EPSDT, or a similar program, at the time of submission of the HCBS Waiver Application to the CMA or DHCS.
2. Individuals residing in the community and at risk of institutionalization within 30 days 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 six opportunities for waiver enrollment to individuals 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 and individuals aging out of EPSDT or similar programs. The second four opportunities for enrollment will be offered to the individuals at the top of the list of individuals residing in the community. 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.

The CMA also works closely with CCT, a program developed to assist Medi- Cal eligible individuals that have been residing in an institutional setting for at least 90 days, to find services and supports that could help them live in a community setting. Frequently CCT is the CMA or partners with the CMA and refers individuals who have successfully transitioned from a facility to the community, and who meet the medical criteria, for enrollment in the HCB Alternatives Waiver.

Priority Enrollment for Institutional and EPSDT or Similar Programs Transitions

DHCS may reserve Institutional and EPSDT or similar programs transitions allocated waiver slots for priority enrollment to prevent interruption of existing services or prevent unnecessary nursing facility placement for EPSDT or similar programs transitions.

Priority enrollment into the HCB Alternatives Waiver is given only to individuals who meet the following criteria:

1. The individual must be a current Medi-Cal member who will turn 21 years of age during the current waiver year AND must have been receiving or have been authorized for supplemental private duty nursing services for at least six months prior to his/her 21st birthday, through programs such as EPSDT; must submit a completed Waiver Application; and must be medically eligible for placement into the HCB Alternatives Waiver, or
2. The individual must currently reside in an institutional setting and would remain there in the absence of HCB Alternatives Waiver services being provided in the home as a diversionary measure.

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:

Aged, blind and disabled individuals who would otherwise be eligible for SSI/SSP as provided in Section 1902 (a)_(10)(A)(ii)(I), including those who are eligible under Section 1634(a)(c) and (d).

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 7)

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. 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:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑ **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 uses *spousal* post-eligibility rules under §1924 of the Act.**

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (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 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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:

- (●) **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 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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 (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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. 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).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

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:

Local/Regional Non-State Entities also known as CMAs under a contract with DHCS perform level of care initial evaluations and reevaluations.

In areas where there is no CMA, DHCS performs the level of care initial evaluations and reevaluations.

- ( ) **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:

An RN, licensed to practice in the State of California will perform the initial evaluation of the HCB Alternatives Waiver applicants utilizing a face-to-face intake home/community visit.

An RN employed by the CMA will perform the initial LOC evaluation based upon the Case Report. DHCS will review and make the final determination on the LOC evaluation that has been completed by the RN 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 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 HCB Alternatives Waiver.

This waiver will serve disabled Medi-Cal members, 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:

Acute Hospital LOC

The HCB Alternatives Waiver will serve Medi-Cal members who would, in the absence of this waiver, and as a matter of medical necessity, pursuant to California W&I Code, Section (§)14059.5, require services only available in an acute hospital setting for at least 90 consecutive days , pursuant to 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 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) (c) 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.

Subacute LOC

1. NF Subacute Care services, pursuant to Title 22, CCR, §51124.5; or
2. NF Pediatric Subacute Care services, pursuant to Title 22, CCR, §51124.6.

NF A/B LOC

This waiver will serve Medi-Cal members 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 NF providing the following types of care:

1. NF Level A – Intermediate Care services pursuant to Title 22, CCR, §51120 and 51334.
2. NF Level B – Skilled Nursing Facility services pursuant to Title 22, CCR, §51124 and 51335.

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.

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 an HCB Alternatives Waiver Freedom of Choice (FOC) 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;
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.

The IMS/CMR 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 Record is reviewed by DHCS to determine if the CMT 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 (MC) which could be a DHCS RN, a DHCS RN Supervisor, or a physician licensed to practice in the State of California. On approval of the LOC determination, an electronic adjudication is completed by the DHCS Medical Consultant.

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.

In conjunction with the Nursing Facility Level of Care and assessments/reassessments, the CMT uses the IMS and CMR to measure the applicant's condition. The CMT uses available medical documentation as well as in-person observations and interviews to complete the IMS and CMR. The IMS and CMR use the same criteria to determine NF LOC similar to the State Plan. If it is determined that the applicant meets the NF LOC identified, they are determined to be eligible for the waiver.

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

The CMT will assess to determine entrance into the HCB Alternatives Waiver and authorization of services by determining that the HCB Alternatives Waiver services are medically necessary to maintain the applicant's health, welfare, and safety in the community setting or residence under the HCB Alternatives Waiver. The CMT may assess and approve medically necessary services as long as the Waiver services - nursing services provided by licensed personnel (registered nurse, licensed vocational nurse, certified home health aides), habilitation services provided by trained, supervised personnel, and case management services - are medically necessary. Medical necessity is defined as set forth in Welfare and Institutions Code 14059.5, as follows: A service is "medically necessary" or of a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

The CMT utilizes the following procedures to determine in advance of waiver enrollment that the individual's health and welfare can be assured:

When assessing LOC, the CMT reviews the available medical documentation. In addition to the available medical documentation, the CMT reviews other pertinent information in the applicant's record, such as the POT, progress reports, medical and psychological evaluations and case management notes, to determine the Waiver qualifying conditions that significantly affect the applicant's ability to perform activities of daily living and/or participate in community activities.

1. The CMT schedules a face to face intake visit with the potential waiver participant and an evaluation is completed. The CMT utilizes this evaluation to determine if the applicant meets one of the HCB Alternatives Waiver LOCs. The information from the initial visit is documented in the Case Record along with medical justification to support the LOC and the need to receive the type, frequency and amount of services that are currently authorized or being requested by the applicant's current primary care physician to ensure the health and safety of the applicant to return and/or remain safely in his/her home and community. The CMT documents the type, frequency and amount of waiver and State Plan services the applicant is currently receiving or the applicant's current primary care physician has ordered and details it in the Menu of Health Services (MOHS).
2. Upon the determination of the applicant's LOC and the need for services, the CMT provides information to the applicant and/or his/her legal representative/legally responsible adult and/or circle of support on the services available through the HCB Alternatives Waiver. The CMT works with the applicant and/or his/her legal representative/legally responsible adult and/or circle of support, and the applicant's current primary care physician in identifying the State Plan and HCB Alternatives Waiver services that meet the applicant's medically necessary care needs.
3. The type, frequency and amount of the applicant's identified waiver and State plan services are documented in the MOHS worksheet and provided to the applicant and/or his/her legal representative/legally responsible adult prior to enrolling in the HCB Alternatives Waiver. The MOHS is a planning instrument used by the applicant and/or his/her legal representative/legally responsible adult, circle of support, and the CMT to develop a home care program and ensures the applicant's health, safety, and welfare in the community. The MOHS summarizes all the waiver services and provider types available through the HCB Alternatives Waiver. The MOHS enables the applicant 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 medically necessary care needs and ensure his/her health and safety.
4. The CMA submits the completed HCB Alternatives Waiver application, Medi-Cal Eligibility summary report, IMS/CMR and MOHS, also known as the Case Record , to the DHCS MC for approval of waiver enrollment. If DHCS determines the applicant does not meet the medical or health and safety eligibility criteria DHCS will issue a NOA denying enrollment in the HCB Alternatives Waiver.
5. Upon DHCS approval of an applicant's waiver participation, the CMT will authorize the identified medically necessary waiver services at the type, scope, frequency and amount as described in the approved MOHS.

The CMT conducts a complete LOC evaluation/reevaluation of the applicants or participants medical need for waiver services. The initial evaluation and reevaluations for LOC are documented in the Case Record. The evaluation and reevaluations include identification of a current 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, and confirmation that a medical need exists for the level of services requested.

For a complete description of the LOC criterion that are used to evaluate and reevaluate an applicant or participant's need for waiver services, refer to Appendix B Section 1.b. Once the evaluation visit is completed, the CMT uses the CMR to document the individual's LOC and medically necessary care needs, including identification of caregivers and support systems; a home safety evaluation and concerns or issues identified by the applicant or participant, his/her circle of support, caregivers or the CMT. The CMR also documents plans for resolution of issues identified during the evaluation for waiver enrollment. The CMA provides a justification and recommendation to the DHCS MC for the applicant or participant's LOC in the Case Record.

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 CMT uses the Care Management Acuity System to determine the periodicity of reevaluations and the intensity of the required participant case management. Information collected during the initial evaluation and later reevaluations is documented in the CMR and is used to determine a participant's level of care management. HCB Alternatives Waiver participants are assigned a level of care 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 CMT will conduct on-site home visits based upon the level of care 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.

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.

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 CMT.

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 the current primary care physician ordered medically-necessary services.

Level 4 - participants are reevaluated more frequently than once every 180 days. Participants require frequent monitoring and interventions by the CMT to address issues that affect their health and safety and are at an elevated risk. The CMT 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 HCBS waiver providers responsible for rendering waiver 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)*:

Reevaluations of the Waiver Participant's LOC are conducted at a minimum of every 365 days. Quality Assurance Reviews (QAR) are conducted by DHCS. DHCS analyzes case records, progress notes, assessment/reassessments, the Participant's POT and any other documentation pertinent to determining that:

1. Documentation supports that LOC criteria have been met,
2. Evaluations and reevaluations are timely,
3. Documentation has been completed by the appropriate CMT personnel.

If deficiencies in LOC reevaluations are identified, the written report of the findings and recommendations issued to the CMA by DHCS will include a formal written request for a Corrective Action Plan (CAP) specific to remediating the deficiencies. The CMA is required to respond to DHCS within 30 days of the date of the QAR report and develop a formal CAP to address any deficiencies identified. Upon receipt of the CAP, DHCS monitors the CMA's resolution process to ensure complete remediation of the deficiency(ies). Once the CAP is reviewed and approved for

implementation by DHCS, the CMA is given an opportunity to implement the developed strategy. Once adequate time for implementation has occurred, DHCS may conduct an on-site follow-up visit to the CMA to evaluate the effectiveness of the CMA's new practice, and/or request submission of records for additional review by DHCS. DHCS will issue an approval letter once it has been verified that the CMA has appropriately remediated the issues addressed in the CAP. Technical assistance is provided throughout the process on an as needed basis.

In areas where there are no CMAs, DHCS generates quarterly reports from the Care Management database. The database tracks the date of last evaluation and the date when the participant requires a reevaluation. Quarterly tracking reports are distributed to DHCS MCs 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 CMA.

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**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 HCB Alternatives 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:
Case Records, Files and Paid Claims

Responsible Party for data	Frequency of data collection/generation	Sampling Approach *(check each that applies):*

collection/generation *(check each that applies):*	*(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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 HCB Alternatives Waiver participants who received a timely LOC redetermination at least 12 months from their previous or initial LOC evaluation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Reports and Files

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:

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 Waiver participant's LOC determinations that were completed by qualified personnel, 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 =

☐ **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 utilizes CMIS, MedCompass, and the Quality Assurance Reviews which include case and provider record reviews to monitor the timeliness and accuracy of the initial and reevaluated LOC determinations.

CMIS and subsequently MedCompass captures the data documenting:
• The CMA or DHCS received HCBS Waiver Application;
• The CMA or DHCS reviewed HCBS Waiver Application;
• Receipt of an applicant's evaluation prior to enrollment in the HCB Alternatives Waiver;
• Enrollment of an applicant in the HCB Alternatives Waiver; and
• The next re-evaluation visit due date, based upon the level of case management.

The Quality Assurance Review conducted by DHCS evaluates the accuracy of the LOC determination based on the information documented in the participant's case report.

The CMA Team is responsible for the evaluation visit and DHCS maintains waiver eligibility determination. The CMA Team consists of at least one RN and MSW, as applicable. The CMA Team must submit evidence of the evaluation visit and documentation of the applicant's appropriate LOC to DHCS before the applicant is enrolled in the HCB Alternatives Waiver. DHCS determines the applicant's eligibility and confirms LOC. CMIS and subsequently MedCompass 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. Enrolled status into the waiver is documented by entering the date the participant was approved eligible for the HCB Alternatives Waiver.

Re-evaluations of LOC determinations are conducted as described in Appendix B. The CMT is responsible for the timeliness of LOC re-evaluations. DHCS uses CMIS and subsequently MedCompass 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 CMA submits a quarterly report to DHCS that identifies participants who have not had their LOC re-evaluation completed within 60 days, and a plan or schedule for completing the overdue home visits.

DHCS is responsible for conducting biennial onsite Care Management Agency (CMA) Quality Assurance Reviews and, in areas where there is no CMA, DHCS clinical reviews which will consist of Case Record Reviews on active HCB Alternatives 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. DHCS 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, DHCS selects the cases for review based upon the corresponding percentage of participants at each level of care (LOC) by the CMT.

The CMT 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 CMT documents the participant's medically necessary care needs and the justification of the LOC in the CMR and submits to DHCS. DHCS uses the CMR criteria and regulations cited in the HCB Alternatives Waiver in verifying the LOC determination.

Once DHCS has determined the CMR is complete and is in agreement with the LOC determination, DHCS signs and dates the case report. If DHCS and the CMT are not in agreement with the LOC determination the CMR is reviewed by another DHCS MC. The DHCS MC's LOC determination is final and documented in the case report.

The Quality Assurance Review is used to discover the CMA's level of compliance with completing the CMR and reviews the LOC determinations to determine if they are in compliance with the HCB Alternatives Waiver. Within 30 days of the review, DHCS will present an analysis of the findings to the CMA. Based upon the findings and level of compliance, remediation actions will be developed and implemented within 30 days by the CMA. Remediation actions may include identification of individuals in the CMT 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 DHCS through monthly follow-up discovery activities, when necessary, to determine the effectiveness of the remediation actions.

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 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 in the HCB Alternatives Waiver. Information is provided verbally and in writing through use of the FOC and “Informing Notice”.

A signed FOC 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 HCB Alternatives Waiver enrollment, the CMT sends to the participant and/or his/her legal representative/legally responsible adult(s) a FOC letter and form for their signature. The participant’s and/or his/her legal representative/legally responsible adult(s)’ signature is acknowledgment that the CMT has described the services available under the HCB Alternatives Waiver which are provided as an alternative to care in a licensed heath care facility. The FOC 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 FOC form and letter is the “Informing Notice” which describes the roles and responsibilities of the

participant, his/her legal representative/legally responsible adults, the CMT, the waiver providers, and the participant's current primary care physician. The "Informing Notice" is resent whenever there is a change in the CMA, the provider of service or the participant's current primary care physician.

The participant and/or his/her legal representative/legally responsible adult(s) are advised to return the signed and dated FOC form within five days of receipt. Waiver services are not approved for the participant until the signed and accepted FOC is received by the CMT. If a signed and accepted FOC is not received by the CMT within 30 days of the date the FOC was mailed to the participant, enrollment in the HCB Alternatives 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 FOC form is maintained in the participant's case record file at the designated CMT 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:

A key component of case management is conducting community outreach to expand waiver enrollment, reach populations and/or groups in the community who are institutionalized or at risk of institutionalization, and provide meaningful access to services for all persons, including those with Limited English Proficiency (LEP).

• CMAs implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
• CMAs ensure that participants receive, from all staff members, effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs, practices and preferred language.
• DHCS requires CMAs to provide linguistic diversity in service providers to allow participants an opportunity for selection and participant choice.
• HCB Alternatives Waiver required participant forms are available in English with taglines in 15 other languages so that participants may request translation in their preferred language. Currently, there is no need for client forms in other languages.

If the need arises, DHCS will ensure forms are translated as requested.

DHCS and CMAs do not discriminate

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	Waiver Personal Care Services (WPCS)	

Service	
Other Service	Community Transition Services
Other Service	Continuous 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

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
This service is intensive and comprehensive care management ensuring stabilization and access to HCBS interspersed with managing and anticipating episodes of medical crisis in which transitional care management is needed. The model of care will:

1. Assess medical needs including diagnosis, functional and cognitive abilities, and environmental and social needs;
2. Anticipate changes in health, social, functional and environmental status;
3. Anticipate, identify, understand and address existing barriers and challenges and changes in the supports and services system while informing DHCS of the challenges;
4. Care planning to mitigate risk;
5. Provide linkages to community-based services;
6. Monitor delivery and quality of services and changes in health, social, functional and environmental status; and
7. Adjust care plans, as appropriate.

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, safety and support of his/her home and community-based program. Case Managers/Coordinators of the CMA Team or HCBS Providers also assist in acquiring personal care providers as described in the participant's plan of care.

The CMT works with the participant, his/her legal representative/legally responsible adult and/or circle of support, and primary care physician in developing goals and identifying a course of action to respond to the assessed needs of the participant, and in the development and updating of the participant's current primary care physician-signed POT. In signing the POT, the participant's current primary care physician is attesting to the medical necessity of the waiver services identified in the POT. The CMT authorizes and assists the participant in understanding the various medically necessary 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 medically necessary waiver services described in the POT, and evaluate the effectiveness of those services. Case Management/Coordination responsibilities include assessing, authorizing, 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.

When a participant does not have a CMA, the 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) individual providers. A WPCS individual provider is employed directly by the waiver participant.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
CMAs are reimbursed a monthly flat fee per enrolled participant.

The CMT uses the Care Management Acuity System to determine the periodicity of the participant's required case management. Information collected during the initial evaluation and later reevaluations is documented in the Case Record and is used to determine a participant's level of care management. HCB Alternatives Waiver participants are assigned a level of care management of 1 through 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 CMT will conduct on-site home visits based upon the level of care management acuity, or as necessary, to assess the effectiveness of the home program in ensuring the participant's health, safety and adherence to the POT.

Level 1 - participants are visited 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.

Level 2 - participants are visited more often, between 270 and 365 days. Participants have minor staffing or durable medical equipment issues and maintains regular contact with the CMT.

Level 3 - participants are visited 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 the current primary care physician ordered medically-necessary services.

Level 4 - participants are visited more frequently than once every 180 days. Participants require frequent monitoring and interventions by the CMT to address issues that affect their health and safety and are at an elevated risk. The CMT 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 services in response to issues requiring a plan of correction and follow-up.

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

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

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

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

Provider Specifications:

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

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)*:
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 HCB Alternatives Waiver contract and Medi- Cal Provider requirements may provide HCB Alternatives Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following HCB Alternatives Waiver services:

• Case Management (CM)
• Community Transition Services (CTS)
• Transitional Case Management (TCM)

The Non-Profit Organization must provide Case Management/Coordination services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience as follows:

1. Develop the HCB Alternatives 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 participant's current primary care physician's orders for care. Collaborate with the participant and the participant's current 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, medically necessary services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes.
2. 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 participant's current primary care physician and/or DHCS of the participant's status to update or revise the POT as directed by the participant in collaboration with the participant's current 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 their current primary care physician no less frequently than once every six months. In signing the POT, the participant's current primary care physician is attesting to the medical necessity of the waiver services identified in the POT.
3. Submit the POT to the DHCS MC for approval of HCB Alternatives Waiver enrollment and services.
A. The POT and supporting documents will be reviewed 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.
B. Additional documentation supporting the medical necessity of the services described in the POT may be requested and any necessary or suggested revisions of the POT will be discussed with the CMT. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult (s). Enrollment in the HCB Alternatives Waiver or authorization of 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.

4. Authorize the provision of HCB Alternatives Waiver services by the CMA network of providers as described on the participant's POT and as approved by the DHCS MC.
5. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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:
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.
CCR Title 16, §§1380 et seq
Certificate *(specify):*

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the HCB Alternatives Waiver, the role of a Licensed Psychologist as a direct Waiver Service Provider is to provide:

• Case Management (CM)
• Community Transition Service (CTS)
• Transitional Case Management (TCM)

A Licensed Psychologist who functions as an HCB Alternatives 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 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.
4. Provide case management services within the scope of practice of a Licensed Psychologist consistent with the participant's current primary care physician's orders and the POT as approved by the CMA or DHCS as follows:
A. Develop the POT consistent with the assessment of the waiver participant and the participant's current primary care physician's orders for care. Collaborate with the waiver participant's current 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 participant's current primary care physician of the waiver participant's status and update or revise the POT as directed by the participant's current primary care physician to reflect the medical needs of the waiver participant, as determined by the participant's current 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 participant's current primary care physician no less frequently than once every six months.
C. Submit the POT to the DHCS MC for approval of HCB Alternatives Waiver enrollment and services.
i. The POT and supporting documents will be reviewed 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.
ii. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval

of 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.

D. Authorize the provision of HCB Alternatives Waiver services by the participants selected network of providers as described on the participant's POT and as approved by the DHCS MC.

E. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 Board of Psychology

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:

Professional Corporation

Provider Qualifications

License *(specify):*

CC §13401(b)

Certificate *(specify):*

Other Standard *(specify):*

HCB Alternatives Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide services approved under the HCB Alternatives 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 HCB Alternatives Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:

• Case Management
• Community Transition Services (CTS)
• Transitional Case Management (TCM)

Provide case management services consistent with the participant's current primary care physician's orders and the POT within the scope of the licensed person's scope of practice as follows:

1. Develop the POT consistent with the assessment of the waiver participant and the participant's current primary care physician's orders for care. Collaborate with the waiver participant's current 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
2. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the participant's current primary care physician of the waiver participant's status and update or revise the POT as directed by the participant's current primary care physician to reflect the medical needs of the waiver participant, as determined by the participant's current 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 participant's current primary care physician no less frequently than once every six months.
3. Submit the POT to the DHCS MC for approval of HCB Alternatives Waiver enrollment and services.
A. The POT and supporting documents will be reviewed 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.
B. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the DHCS MC and any necessary or suggested revisions of the POT will be discussed with the CMA. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or authorization of 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.

4. Authorize the provision of HCB Alternatives Waiver services by the CMA network of providers as described on the participant's POT and as approved by the DHCS MC.
5. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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:
DHCS and/or CMA
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 - –Marriage and Family Therapist (MFT)
Provider Qualifications

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

Other Standard *(specify):*
An MFT is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for an MFT. Under the HCB Alternatives Waiver, the role of an MFT as an HCB Alternatives Waiver Service Provider is to provide:

• Case Management (CM)
• Community Transition Service (CTS)
• Transitional Case Management (TCM)

An MFT who functions as a direct HCB Alternatives Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as an 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.
4. Provide medically necessary case management services consistent with the participant's current primary care physician's orders and the POT as approved by the CMT if not the direct service provider, as follows:

A. Develop the POT consistent with the assessment of the waiver participant and the participant's current primary care physician's orders for care. Collaborate with the waiver participant's current primary care physician in the development of the POT to ensure the waiver participant's medical care needs are addressed. The POT will identify all of the services rendered to meet the needs of the waiver participant, the providers of those services and the expected outcomes.

B. Within the MFT's scope of practice, facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the participant's current primary care physician of the waiver participant's status and update or revise the POT as directed by the participant's current primary care physician to reflect the medical needs of the waiver participant, as determined by the participant's current 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 participant's current primary care physician no less frequently than once every six months.

C. Submit the POT to the DHCS MC for approval of HCB Alternatives Waiver enrollment and services.

i. The POT and supporting documents will be reviewed 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.

ii. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

D. Authorize the provision of HCB Alternatives Waiver services by the participant's selected network of providers as described on the participant's POT and as approved by the DHCS MC.

E. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 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)
Provider Qualifications
License *(specify):*
HHA CCR Title 22 §§74659 et seq.
CCR Title 22, §51067;
CCR 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 –- RN
Provider Qualifications
License *(specify):*
BPC §§ 2725 et seq.
CCR Title 22, §51067;
CCR Title 16, §§1409-1419.4
Certificate *(specify):*

Other Standard *(specify):*
Under the HCB Alternatives Waiver, the role of the HCB Alternatives Waiver RN provider is to provide:

• Case Management
• Community Transition Service
• Transitional Case Management

Definitions:

"HCB Alternatives Waiver Nurse Provider" means a Registered Nurse who provides HCB Alternatives Waiver RN services, as defined 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 HCB Alternatives Waiver population, an HCB Alternatives 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

An HCB Alternatives Waiver RN may be a parent, stepparent, foster parent of the participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers or CMAs. DHCS may require additional documentation to support requests of this nature. Documentation required before DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCB Alternatives 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 selected or refused employment, if offered.

"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.

"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 prior to enrollment and when requested.

Requirements of the HCB Alternatives Waiver RN:

AN RN acting as the direct care provider:

1. The initial HCB Alternatives Waiver provider enrollment application shall be accompanied by all of the following documentation:
A. Current, unencumbered license to practice as an RN in the State of California.
B. Current Basic Life Support (BLS) certification.
C. Written evidence, in a format acceptable to DHCS, of training or experience, which shall include at least one of the following:
i. 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 provider enrollment application. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.
ii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
iii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
iv. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specific to Waiver eligibility criteria on the provider enrollment application.

2. A detailed POT that reflects an appropriate nursing assessment of the waiver participant, interventions, and the participant's current primary care physician's orders, as follows:
A. The appropriateness of the nursing assessment and interventions shall be determined by the DHCS MC 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 current primary care physician, and shall contain the dates of service.

3. Signed release form from the waiver participant's current primary care physician, which shall specify both of the following:
A. The participant's current 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 participant's current primary care physician is willing to accept responsibility for the care rendered to the waiver participant.

4. Written home safety evaluation, in a format acceptable to DHCS 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.

5. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's current primary care physician within the previous three months for an individual under the age of 21 and within the previous six months for an individual 21 years of age or older. If the last history and physical was completed outside of the respective timeframes, the history and physical shall be accompanied by documentation of the most recent office visit, which shall contain a detailed summary of medical findings that includes a body systems examination.
6. Annually the HCBS Waiver nurse provider shall submit the following documentation to DHCS:
A. Evidence of renewal of BLS certification and unencumbered RN licensure prior to expiration.
B. Written evidence, in a format acceptable to DHCS, 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. Written evidence, in a format acceptable to DHCS, of on-going contact with the waiver participant's current primary care physician for the purpose of informing the participant's current primary care physician of the individual's progress, updating, and renewal of the participant's current primary care physician orders.

7. Evaluation of the case management and/or waiver coordination activities provided.
8. Written evidence of ongoing contact with the waiver participant's current primary care physician, as specified in "requirements of the HCB Alternatives Waiver RN", above.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing

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
CCR Title 16, §§1870-1881

Certificate *(specify):*

Other Standard *(specify):*
HCBS HCB Alternatives Waiver Standards of Participation

An LCSW is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the HCB Alternatives Waiver the role of a LCSW as a HCB Alternatives Waiver Service Provider is to provide:
• Case Management (CM)
• Community Transition Service (CTS)
• Transitional Case Management (TCM)

A LCSW who functions as an HCB Alternatives 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.
4. Provide case management or transitional case management services within the scope of practice of a LCSW consistent with the participant's current primary care physician's orders and the POT as authorized by DHCS, as follows:

A. Develop the POT consistent with the assessment of the participant and their current primary care physician's orders for care. Collaborate with the participant's current primary care physician in the development of the POT to ensure the member's medically necessary care needs are addressed. The POT will identify all of the services rendered to meet the needs of the participant, the providers of those services and the expected outcomes.
B. Facilitate the process of assessing the participant at the frequency described in the POT for progress and response to the POT. Inform the participant's current primary care physician of the participant's status and update or revise the POT as directed by the participant's current primary care physician to reflect the medical needs of the participant, as determined by the participant's current primary care physician. Assist the participant in accessing medical care services that are beyond the LCSW's scope of practice. The POT is updated and signed by the participant's current 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: 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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Habilitation Services are provided in a participant's home or an out-of-home non-facility setting designed to assist the participant in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment 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.

When a participant does not have a CMA Team, the HCBS individual provider may provide Habilitation services following approval from the DHCS MC.
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 Psychologist
Agency	Non-Profit Agency
Agency	Professional Corporation
Individual	HCBS Benefit Provider - LCSW
Individual	HCBS Waiver Nurse Provider - RN
Agency	HHA
Individual	HCBS Benefit Provider - MFT

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.
CCR Title 16, §§1380 et seq.
Certificate *(specify):*

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the HCB Alternatives Waiver, the role of a Licensed Psychologist as a direct Waiver Service Provider is to provide:

• Habilitation Services (HS)

A Licensed Psychologist who functions as an HCB Alternatives 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 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.
4. Provide case management services within the scope of practice of a Licensed Psychologist consistent with the participant's current primary care physician's orders and the POT as approved by the CMA or DHCS as follows:

A. Provide the participant's medically necessary case management services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT, if not acting as the care manager, of the participant's status which reflect the medical needs of the participant. Assist the participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice.
B. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.

i. The POT and supporting documents will be reviewed 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.
ii. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

C. Provide the HCB Alternatives Waiver habilitation services as described on the participant's POT and as approved by the CMA or DHCS MC.
D. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 Board of Psychology
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):*
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 HCB Alternatives Waiver SOP and Provider requirements may provide HCB Alternatives Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following direct HCB Alternatives Waiver services:

• Habilitation Services

The Non-Profit Organization must provide habilitation services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.
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:
Professional Corporation
Provider Qualifications
License *(specify):*
CC §13401(b)
Certificate *(specify):*

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide services approved under the HCB Alternatives 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 HCB Alternatives Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:

• Habilitation Services

A Professional Corporation must provide habilitation services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCS and/or CMA
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 - LCSW
Provider Qualifications

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

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

An LCSW is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for an LCSW. Under the HCB Alternatives Waiver, the role of an LCSW as a direct HCB Alternatives Waiver Service Provider is to provide:

• Habilitation Services

An LCSW who functions as an HCB Alternatives Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as an 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 LCSW must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by the CMA and DHCS.
4. Provide the participant's medically necessary habilitation services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT, if not acting as the care manager, of the participant's status which reflect the medical needs of the participant. Assist the participant in accessing medical care services that are beyond the LCSW's scope of practice.
5. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.

A. The POT and supporting documents will be reviewed 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.

B. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

6. Provide the HCB Alternatives Waiver habilitation services as described on the participant's POT and as approved by the CMA or DHCS MC.

7. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 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 Waiver Nurse Provider - RN

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Under the HCB Alternatives Waiver, the role of the HCB Alternatives Waiver RN provider is to provide:

• Habilitation Services

"HCB Alternatives Waiver Nurse Provider" means a Registered Nurse who provides HCB Alternatives Waiver RN related services, as defined 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 HCB Alternatives Waiver population, a HCB Alternatives 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
• RN is on probation and have violated their probation conditions

An HCB Alternatives Waiver RN may be a parent, stepparent, foster parent of a participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers or CMAs. DHCS may require additional documentation to support requests of this nature. Documentation required before DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCB Alternatives 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 selected or refused employment, if offered.

"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.

"Evaluation of theoretical knowledge and manual skills" means an assessment conducted by the RN of the 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 prior to enrollment and when requested.

Requirements of the HCB Alternatives Waiver RN:

RN acting as the direct care provider:

1. The initial HCB Alternatives Waiver provider enrollment application shall be accompanied by all of the following documentation:
   A. Current, unencumbered license to practice as an RN in the State of California.
   B. Current BLS certification.
   C. Written evidence, in a format acceptable to DHCS, of training or experience, which shall include at least one of the following:
      i. 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 provider enrollment application. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.
      ii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
      iii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
      iv. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specific to Waiver eligibility criteria on the provider enrollment application.

2. A detailed POT that reflects an appropriate nursing assessment of the waiver participant, interventions, and the participant's current primary care physician's orders.
3. 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).
4. The POT shall be signed by the waiver participant, the RN, and the waiver participant's current primary care physician, and shall contain the dates of service.
5. Signed release form from the waiver participant's current primary care physician, which shall specify both of the following:
A. The participant's current 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.

6. The participant's current primary care physician is willing to accept responsibility for the care rendered to the waiver participant.
7. Written home safety evaluation, in a format acceptable to the CMA or DHCS 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.

8. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's current primary care physician within the previous three months for an individual under the age of 21 and within the previous six months for an individual 21 years of age or older. If the last history and physical was completed outside of the respective timeframes, the history and physical shall be accompanied by documentation of the most recent office visit, which shall contain a detailed summary of medical findings that includes a body systems examination.
9. Annually the HCBS Waiver nurse provider shall submit the following documentation to the CMA or DHCS:
A. Evidence of renewal of BLS certification and unencumbered RN licensure prior to expiration.
B. Written evidence, in a format acceptable to DHCS, 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. Written evidence, in a format acceptable to DHCS, of on-going contact with the waiver participant's current primary care physician for the purpose of informing the participant's current primary care physician of the individual's progress, updating, and renewal of the participant's current primary care physician orders.

10. Evaluation of habilitation services provided.
11. Written evidence of ongoing contact with the waiver participant's current primary care physician, as specified in "requirements of the HCB Alternatives Waiver RN", above.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Registered Nursing

Frequency of Verification:

Annually

Appendix C: Participant Services

Service Type: Statutory Service
Service Name: Habilitation Services

Provider Category:
Agency
Provider Type:
HHA
Provider Qualifications
License *(specify):*
HHA Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR 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: Habilitation Services

Provider Category:
Individual
Provider Type:
HCBS Benefit Provider - MFT
Provider Qualifications
License *(specify):*
BPC §§4980-4989
Title 16, §§1829-1848
Certificate *(specify):*

Other Standard *(specify):*
An MFT is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for an MFT. Under the HCB Alternatives Waiver, the role of an MFT as an HCB Alternatives Waiver Service Provider is to provide:

• Habilitation Services

An MFT who functions as a direct HCB Alternatives Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as an 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.
4. Provide medically necessary case management services consistent with the participant's current primary care physician's orders and the POT as approved by the CMT if not the direct service provider, as follows:

A. Within the MFT's scope of practice, providing the waiver participant's medically necessary case management services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT if not the direct service provider of the waiver participant's status which reflect their medical needs. Assist the waiver participant in accessing medical care services that are beyond the MFT's scope of practice.
B. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.

i. The POT and supporting documents will be reviewed 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.
ii. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

C. Provide the HCB Alternatives Waiver Habilitation services as described on the participant's POT and as approved by the CMA or DHCS MC.
D. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 Board of Behavioral Sciences
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

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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 or approved by the CMA or DHCS MC. When a participant does not have a CMA, the HCBS individual provider may provide Home Respite services following approval from the DHCS MC.

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 current 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:
The CMA 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), 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**
- [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	Non-Profit Agency
Individual	Waiver Personal Care Service (WPCS) Provider
Agency	HHA
Individual	HCBS Waiver Nurse Provider - RN
Agency	Personal Care Agency
Agency	Employment Agency
Individual	HCBS Waiver Nurse Provider - LVN

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)*:
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 HCB Alternatives Waiver SOP and Provider requirements may provide HCB Alternatives Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following direct HCB Alternatives Waiver services:

• Home Respite

The Non-Profit Organization must provide home respite services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.

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

Appendix C: Participant Services

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 & HCB Alternatives Waiver Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
DHCS
Frequency of Verification:
Upon request of services

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:
HHA
Provider Qualifications
License *(specify):*
HHA CCR Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR 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: Home Respite

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

Other Standard *(specify):*
Under the HCB Alternatives Waiver, the role of the HCB Alternatives Waiver RN provider is to provide:

• Home Respite

"HCB Alternatives Waiver Nurse Provider" means a Registered Nurse who provides HCB Alternatives Waiver RN related services, as defined 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 HCB Alternatives Waiver population, a HCB Alternatives 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
• RN is on probation and have violated their probation conditions

An HCB Alternatives Waiver RN may be a parent, stepparent, foster parent of a participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers or CMAs. DHCS may require additional documentation to support requests of this nature. Documentation required before DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCB Alternatives 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 selected or refused employment, if offered.

"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.

"Evaluation of theoretical knowledge and manual skills" means an assessment conducted by the RN of the 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 prior to enrollment and when requested.

Requirements of the HCB Alternatives Waiver RN:

RN acting as the direct care provider:

1. The initial HCB Alternatives Waiver provider enrollment application shall be accompanied by all of the following documentation:
A. Current, unencumbered license to practice as an RN in the State of California.
B. Current BLS certification.
C. Written evidence, in a format acceptable to DHCS, of training or experience, which shall include at least one of the following:
i. 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 provider enrollment application. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.
ii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
iii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
iv. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specific to Waiver eligibility criteria on the provider enrollment application.

2. A detailed POT that reflects an appropriate nursing assessment of the waiver participant, interventions, and the participant's current primary care physician's orders.
3. 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).
4. The POT shall be signed by the waiver participant, the RN, and the waiver participant's current primary care physician, and shall contain the dates of service.
5. Signed release form from the waiver participant's current primary care physician, which shall specify both of the following:
A. The participant's current 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.

6. The participant's current primary care physician is willing to accept responsibility for the care rendered to the waiver participant.
7. Written home safety evaluation, in a format acceptable to the CMA or DHCS 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.

8. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's current primary care physician within the previous three months for an individual under the age of 21 and within the previous six months for an individual 21 years of age or older. If the last history and physical was completed outside of the respective timeframes, the history and physical shall be accompanied by documentation of the most recent office visit, which shall contain a detailed summary of medical findings that includes a body systems examination.
9. Annually the HCBS Waiver nurse provider shall submit the following documentation to the CMA or DHCS:
A. Evidence of renewal of BLS certification and unencumbered RN licensure prior to expiration.
B. Written evidence, in a format acceptable to DHCS, 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. Written evidence, in a format acceptable to DHCS, of on-going contact with the waiver participant's current primary care physician for the purpose of informing the participant's current primary care physician of the individual's progress, updating, and renewal of the participant's current primary care physician orders.

10. Evaluation of home respite services provided.
11. Written evidence of ongoing contact with the waiver participant's current primary care physician, as specified in "requirements of the HCB Alternatives 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: 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 & HCB Alternatives Waiver Standards of Participation

A Personal Care Agency is a provider that employs individuals who provide WPCS, is enrolled as an HCB Alternatives Waiver Personal Care Agency provider in the HCB Alternatives Waiver, and meets and maintains SOP minimal qualifications for a Personal Care Agency. Under the HCB Alternatives Waiver, the role of the Personal Care Agency as an HCB Alternatives Waiver Service Provider is to provide:

• Respite care

A Personal Care Agency must provide respite services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.

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: 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 & HCB Alternatives 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 HCB Alternatives Waiver Employment Agency provider under a CMA in the HCB Alternatives Waiver, and meets and maintains the Standards of Participation (SOP) minimal qualifications for an Employment Agency.

Under the HCB Alternatives Waiver, the role of the Employment Agency as an HCB Alternatives Waiver Service Provider is to provide:

• Respite

An Employment Agency must provide respite services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHCS and/or CMA
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 - LVN
Provider Qualifications
License *(specify):*
BPC §§2859-2873.7

Title 22, §51069;
Certificate *(specify):*

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

Under the HCB Alternatives Waiver, the role of the HCBS Waiver Nurse Provider – LVN is to provide:
• Respite Care

"HCBS Waiver Nurse Provider – 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 HCB Alternatives Waiver population, a HCB Alternatives Waiver Nurse Provider application will not be processed, or a subcontract will not be entered into, 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 HCB Alternatives 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 or CMAs. DHCS may require additional documentation to support requests of this nature. Documentation required before DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCB Alternatives 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 selected or refused employment, if offered.

"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 acting as the direct care provider:
1. At the time of provider enrollment, the application 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, of training or experience, as specified in "requirements of the HCBS Waiver LVN", above.

2. Annually the HCBS Waiver nurse provider shall submit the following documentation to DHCS:

A. Evidence of renewal of BLS certification and unencumbered LVN licensure prior to expiration.
B. If services have been rendered within the last 12 calendar months, written evidence, in a format acceptable to DHCS, 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. If services have been rendered within the last 12 calendar months, a copy of the most recent POT that reflects the on-going RN assessment and updated primary care physician orders. The POT shall be signed by the supervising RN, the waiver participant's current primary care physician, the waiver participant and the LVN, and shall contain the dates of service.

3. Evaluation of respite services provided.
A. If services have been rendered within the last 12 calendar months, written evidence of ongoing contact with the supervising RN and waiver participant's current primary care physician. participant's current primary care physician
B. If home respite is regularly scheduled, the HCBS Waiver LVN must notify DHCS 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 DHCS.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Board of Vocational Nursing and Psychiatric Technicians
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)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
WPCS was established by legislation in 1998 through Assembly Bill (AB) 668 which added Section 14132.97 to the 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 current 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 current 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.

WIC Section 14132.97 (d)(4) affords an IHSS Public Authority the option of enrolling as a WPCS waiver provider. DHCS works collaboratively with the California Public Authority Association and the California Department of Social Services (DSS) to make this option available. 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 HCB Alternatives Waiver.

Waiver participants whose complex medical care needs meet the acute hospital facility LOC, requiring frequent evaluation and/or intervention by a RN or LVN who is skilled and knowledgeable in evaluating the participant's medical needs and administering technically complex care as ordered by the participant's current 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 CMA or DHCS MC, for the initial and reauthorization/reapproval 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 WIC 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 the CMA or DHCS 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 11:00a.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 Waiver participant receiving WPCS services under the waiver.
A. Individuals are permitted to enroll in the Medi-Cal program as a Personal Care Service provider pursuant to WIC section 14132(t) and Title 22, 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 HCB Alternatives Waiver SOP;
3. A Personal Care Agency, as defined in the HCB Alternatives Waiver SOP;
4. An HHA WPCS provider. Pursuant to the authority under WIC 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 in the Medi-Cal program. An 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 HCB Alternatives 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 (such as IHSS services) and/or WPCS benefits, must receive that care from two or more State Plan (such as IHSS) and/or WPCS providers. A WPCS provider will not be paid to work more than 12 combined hours per day.

Each individual enrolled as a WPCS provider must submit a written summary with his/her signed Time Report to the CMA or DHCS 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 POT to the CMA or DHCS for prior authorization or approval of WPCS. The POT must be signed by a representative of the agency submitting the POT and the waiver

participant's current primary care physician.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
DHCS 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, IHSS, 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.

Overtime:
On October 1, 2013, the United States Department of Labor published the Final Rule on applying the Fair Labor Standards Act (FLSA) to domestic service providers, which went into effect on February 1, 2016. FLSA overtime rule requires overtime (time and a half) pay for IHSS and WPCS providers when they work more than 40 hours in a workweek. The workweek begins at 12 a.m. on Sunday, and ends at 11:59 p.m. the following Saturday. A single provider who works for a single participant can work up to 70-hours and 45-minutes of combined IHSS and WPCS hours in one workweek. A single provider who works for multiple participants cannot work more than 66 hours in one workweek. WPCS hours will continue to be subject to a maximum work day of 12 hours. The waiver participant may be required to select one or more additional providers to ensure sufficient hours of care are provided each day. Each provider must establish a regular workweek schedule for each participant they serve, not to exceed the 70-hours and 45-minutes of IHSS and WPCS combined, and not to exceed the participant's authorized weekly and monthly hours.

Travel Time:
Beginning February 1, 2016, WPCS providers who work for more than one participant may be eligible for travel time up to 7 hours per workweek. If the provider works over 40 hours in one workweek, travel time will be paid at time and a half. Travel time is the time it takes to travel directly from one participant to another on the same day to provide WPCS only or both WPCS & IHSS services.

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	Employment Agency
Individual	WPCS Provider
Agency	Non-Profit Agency
Agency	Personal Care Agency
Agency	HHA

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):*
CMA vendor contract Standards of Participation

An Employment Agency is a provider that employs individuals who provide the WPCS, is enrolled as an HCB Alternatives Waiver Employment Agency provider in the HCB Alternatives Waiver, and meets and maintains the SOP minimal qualifications for an Employment Agency.

Under the HCB Alternatives Waiver, the role of the Employment Agency as an HCB Alternatives Waiver Service Provider is to provide:

• WPCS

An Employment Agency must provide WPCS consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.
Verification of Provider Qualifications
Entity Responsible for Verification:
CMA
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:
WPCS Provider
Provider Qualifications
License *(specify):*
NA
Certificate *(specify):*

Other Standard *(specify):*
Overtime:
On October 1, 2013, the United States Department of Labor published the Final Rule on applying the FLSA to domestic service providers which went into effect on February 1, 2016. FLSAs new overtime rule requires overtime (time and a half) pay for IHSS and WPCS providers when they work more than 40 hours in a workweek. The workweek begins at 12 a.m. on Sunday, and ends at 11:59 p.m. the following Saturday. A single provider who works for a single participant can work up to 70-hours and 45-minutes of combined IHSS and WPCS hours in one workweek. A single provider who works for multiple participants cannot work more than 66 hours in one workweek. WPCS hours will continue to be subject to a maximum work day of 12 combined hours. Each provider must establish a regular workweek schedule for each participant they serve, not to exceed the 70-hours and 45-minutes of IHSS and WPCS combined, and not to exceed the participant's authorized weekly and

monthly hours.

Travel Time:
Beginning February 1, 2016, WPCS providers who work for more than one participant may be eligible for travel time up to 7 hours per workweek. If an individual provider works over 40 hours in one workweek, travel time will be paid at time and a half. Travel time is the time it takes to travel directly from one participant to another on the same day to provide WPCS only or both WPCS & IHSS services.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCS

Frequency of Verification:
At the time of service request and modification

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):*
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 HCB Alternatives Waiver SOP and Provider requirements may provide HCB Alternatives Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following direct HCB Alternatives Waiver services:

• Waiver Personal Care Services (WPCS)

The Non-Profit Organization must provide WPCS consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.

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

Other Standard *(specify):*
CMA vendor contract Standards of Participation

A Personal Care Agency is a provider that must directly employ individuals who provide WPCS, is enrolled as an HCB Alternatives Waiver Personal Care Agency provider in the HCB Alternatives Waiver, and meets and maintains SOP minimal qualifications for a Personal Care Agency. Under the HCB Alternatives Waiver, the role of the Personal Care Agency as an HCB Alternatives Waiver Service Provider is to provide:

• WPCS

A Personal Care Agency must provide WPCS consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.
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: Waiver Personal Care Services (WPCS)

Provider Category:
Agency
Provider Type:
HHA
Provider Qualifications
License *(specify):*
HHA CCR Title 22 §74659 et seq.
Certificate *(specify):*

Other Standard *(specify):*
County IHSS Program Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
CDPH 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:

Community Transition Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from a licensed health care facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include:

1. Security deposits that are required to obtain a lease on an apartment or home;
2. Essential household furnishings and required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
3. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
4. Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
5. Moving expenses;
6. Necessary home accessibility adaptations; and
7. 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 CMT will approve the service after all requested documentation has been received and reviewed, the CMT oversees the administration of the service submits all of the medical documentation and invoices for approval and reimbursement.

The lifetime maximum allowed cost for Community Transition Services is $5,000.00. The CMT will explain to the participant the guidelines of the Community Transition Services under the waiver.

When a participant does not have a CMA, the HCBS individual provider providing Case Management/Coordination services may also provide 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 re-institutionalization.

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

- [ ] **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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	HCBS Benefit Provider - LCSW
Agency	HHA
Agency	Professional Corporation
Individual	HCBS Benefit Provider - Licensed Psychologist
Agency	Non-Profit Agency
Individual	HCBS Benefit Provider - MFT
Individual	HCBS Waiver Nurse Provider - RN

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 - LCSW
Provider Qualifications
License *(specify)*:
BPC §§4990-4998.7

CCR Title 16, §§1870-1881
Certificate *(specify):*

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

An LCSW is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for an LCSW. Under the HCB Alternatives Waiver, the role of an LCSW as a direct HCB Alternatives Waiver Service Provider is to provide:

• Community Transition Services (CTS)

An LCSW who functions as an HCB Alternatives Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as an 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 LCSW must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by the CMA and DHCS.
4. Provide the participant's medically necessary CTS at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT, if not acting as the care manager, of the participant's status which reflect the medical needs of the participant. Assist the participant in accessing medical care services that are beyond the LCSW's scope of practice.
5. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.
   A. The POT and supporting documents will be reviewed 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.
   B. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

6. Provide the HCB Alternatives Waiver CTS as described on the participant's POT and as approved by the CMA or DHCS MC.
7. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 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:
Agency
Provider Type:
HHA
Provider Qualifications
License *(specify):*
HHA CCR Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR 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: 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):*
HCB Alternatives Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide services approved under the HCB Alternatives 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 HCB Alternatives Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:

• Community Transition Services (CTS)

A Professional Corporation must provide community transition services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHCS and/or CMA

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.
CCR Title 16, §§1380 et seq.

Certificate *(specify):*

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the HCB Alternatives Waiver, the role of a Licensed Psychologist as a direct Waiver Service Provider is to provide:

• Community Transition Services (CTS)

A Licensed Psychologist who functions as an HCB Alternatives 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 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.
4. Provide case management within the scope of practice of a Licensed Psychologist consistent with the participant's current primary care physician's orders and the POT as approved by the CMA or DHCS as follows:

A. Provide the participant's medically necessary case management services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT, if not acting as the care manager, of the participant's status which reflect the medical needs of the participant. Assist the participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice.
B. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.

i. The POT and supporting documents will be reviewed 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.
ii. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of

the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

C. Provide the HCB Alternatives Waiver CTS as described on the participant's POT and as approved by the CMA or DHCS MC.

D. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 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:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify)*:

Business license, appropriate for the services purchased

Certificate *(specify)*:

Other Standard *(specify)*:

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 HCB Alternatives Waiver SOP and Provider requirements may provide HCB Alternatives Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following direct HCB Alternatives Waiver services:

• Community Transition Services (CTS)

The Non-Profit Organization must provide CTS consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's registry of Charitable Trusts

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 - MFT
Provider Qualifications
License *(specify):*
BPC §§4980-4989
Title 16, §§1829-1848
Certificate *(specify):*

Other Standard *(specify):*
An MFT is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for an MFT. Under the HCB Alternatives Waiver, the role of an MFT as an HCB Alternatives Waiver Service Provider is to provide:

• Community Transition Service (CTS)

An MFT who functions as a direct HCB Alternatives Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as an 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.
4. Provide medically necessary case management services consistent with the participant's current primary care physician's orders and the POT as approved by the CMT if not the direct service provider, as follows:

A. Within the MFT's scope of practice, providing the waiver participant's medically necessary case management services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT if not the direct service provider of the waiver participant's status which reflect their medical needs. Assist the waiver participant in accessing medical care services that are beyond the MFT's scope of practice.
B. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.

i. The POT and supporting documents will be reviewed 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.
ii. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

C. Provide the HCB Alternatives Waiver CTS services as described on the participant's POT and as approved by the CMA or DHCS MC.
D. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 Board of Behavioral Sciences

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 Waiver Nurse Provider - RN

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Under the HCB Alternatives Waiver, the role of the HCB Alternatives Waiver RN provider is to provide:

• Community Transition Services (CTS)

"HCB Alternatives Waiver Nurse Provider" means a Registered Nurse who provides HCB Alternatives Waiver RN related services, as defined 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 HCB Alternatives Waiver population, a HCB Alternatives 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
• RN is on probation and have violated their probation conditions

An HCB Alternatives Waiver RN may be a parent, stepparent, foster parent of a participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers or CMAs. DHCS may require additional documentation to support requests of this nature. Documentation required before DHCS can authorize such a request, is a written

explanation of the attempts made to enlist and retain an HCB Alternatives 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 selected or refused employment, if offered.

"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.

"Evaluation of theoretical knowledge and manual skills" means an assessment conducted by the RN of the 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 prior to enrollment and when requested.

Requirements of the HCB Alternatives Waiver RN:

RN acting as the direct care provider:

1. The initial HCB Alternatives Waiver provider enrollment application shall be accompanied by all of the following documentation:
   A. Current, unencumbered license to practice as an RN in the State of California.
   B. Current BLS certification.
   C. Written evidence, in a format acceptable to DHCS, of training or experience, which shall include at least one of the following:
      i. 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 provider enrollment application. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.
      ii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
      iii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
      iv. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specific to Waiver eligibility criteria on the provider enrollment application.

2. A detailed POT that reflects an appropriate nursing assessment of the waiver participant, interventions, and the participant's current primary care physician's orders.
3. 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).
4. The POT shall be signed by the waiver participant, the RN, and the waiver participant's current primary care physician, and shall contain the dates of service.
5. Signed release form from the waiver participant's current primary care physician, which shall specify both of the following:
   A. The participant's current 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.

6. The participant's current primary care physician is willing to accept responsibility for the care rendered to the waiver participant.
7. Written home safety evaluation, in a format acceptable to the CMA or DHCS 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.

8. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's current primary care physician within the previous three months for an individual under the age of 21 and within the previous six months for an individual 21 years of age or older. If the last history and physical was completed outside of the respective timeframes, the history and physical shall be accompanied by documentation of the most recent office visit, which shall contain a detailed summary of medical findings that includes a body systems examination.
9. Annually the HCBS Waiver nurse provider shall submit the following documentation to the CMA or DHCS:
A. Evidence of renewal of BLS certification and unencumbered RN licensure prior to expiration.
B. Written evidence, in a format acceptable to DHCS, 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. Written evidence, in a format acceptable to DHCS, of on-going contact with the waiver participant's current primary care physician for the purpose of informing the participant's current primary care physician of the individual's progress, updating, and renewal of the participant's current primary care physician orders.

10. Evaluation of CTS provided.
11. Written evidence of ongoing contact with the waiver participant's current primary care physician, as specified in "requirements of the HCB Alternatives Waiver RN", above.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Board of Registered Nursing
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:
Continuous Nursing and Supportive Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Continuous Nursing and Supportive Services (CNSS) are provided to waiver participant's residing in a CLHF and must be available to waiver participants 24 hours a day, 7 days a week. The CLHF, is a residential facility with a non-institutional, homelike and community integrated environment and is an alternative setting for individuals that require an 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 an RN, 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 CLHF. At no time, can two CNAs or equivalent unlicensed providers be solely responsible for waiver participants, as there must always be an RN or LVN present and "on duty." No nursing personnel shall be assigned housekeeping or dietary duties, such as meal preparation.

RN:

1. An RN will be available on-call to the CLHF with a response time of thirty minutes or less at all times that an 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.

LVN:

1. An LVN shall be in the CLHF and "on duty" at any time that an RN is not onsite.

CNA or equivalent unlicensed provider:

1. An CNA or persons with similar training and experience may be available in the CLHF 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 CLHF.

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

DHCS 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:
DHCS 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	CLHF

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
CLHF
Provider Qualifications
License *(specify):*
HSC §§1250et seq.
CCR Title 22, §§51246 et seq.
Certificate *(specify):*

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

As an HCB Alternatives Waiver Service Provider, the CLHF will provide a home like setting for individuals enrolled in the HCB Alternatives 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 is a residential setting with a non-institutional, homelike environment, having no more than eighteen beds with an option for a private unit ,and provides 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 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.

Legal Authority and Requirements:

1. 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 CCR Title 22 sections 51003 and 51344 and the waiver document.
2. A CLHF must be enrolled as an HCB Alternatives Waiver provider and shall meet the standards specified in the CCR, Title 22, sections 51200(a), 51000.30 through 51000.55, as well as all other laws and regulations applicable to Medi-Cal providers.
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.

Physical Plant and Health and Safety Requirements:

1. 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 setting shall be in a homelike, residential setting. The facility shall provide sufficient space to allow for the comfort, autonomy, dignity 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, control of personal resources, 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 with an option for a private unit. Residents who choose to reside with a roommate will have their choice of a roommates.
E. Bathrooms of sufficient space and quantity shall be provided to allow for the hygiene and personal 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 setting 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. The setting will be physically accessible.

A CLHF Providing Waiver Services:

1. 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 HCB Alternatives 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.

Nursing Services:

1. Pursuant to H&S Code section 1267.13(o)(2)(B) and (o)(2)(C), a CLHF shall provide nursing

services provided by an RN, LVN, and an 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 an RN or LVN present and "on duty." No nursing personnel shall be assigned housekeeping or dietary duties, such as meal preparation.

A. RN

i. An RN will be available on-call to the setting with a response time of thirty minutes or less at all times that an 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 care needs.

B. LVN

i. An LVN shall be in the setting and "on duty" at any time that an RN is not in the setting.

C. CNA or equivalent unlicensed provider

i. An CNA or persons with similar training and experience may be available in the setting to assist the skilled nursing staff (RN and LVN) to meet the requirement of two staff members in the setting.

2. The setting shall provide appropriately qualified staff in sufficient numbers to meet the resident's care needs.

Other Health Related Services:

1. 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

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.

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."

As a Waiver service provider, each HCB Alternatives 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.

Documentation:

1. All Waiver services rendered by the CLHF shall require prior approval and reapproval.
2. 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 DHCS or CMA 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 DHCS or the CMA upon request at any time an enrolled waiver participant is receiving services through a CLHF.

Quality Control/Quality Assurance:

1. Quality control/quality assurance reviews will be in accordance with the Quality Assurance Plan, as described in the approved waiver.

Training Requirements:

1. 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, CMA or the Waiver.
2. 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. CDPH 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.
3. 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:

CDPH 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

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

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. HCB Alternatives Waiver 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:

1. Sufficient RN and 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.

2. 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.
3. A minimum of one RN or one LVN must be in the facility and awake at all times.
4. 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.
5. The following nursing care needs are included within the scope of continuous nursing:
   A. Assistance with ADLs) and instrumental ADLs (IADLs)
   B. Ventilator, tracheostomy and respiratory care
   C. IV therapy
   D. Feeding and elimination care (including tubes)
   E. Medication administration
   F. 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 (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
HCB Alternatives Waiver Standards of Participation (SOP)
Other Standard *(specify)*:
As a HCB Alternatives Waiver Service Provider, the ICF/DD-CN will provide a home-like setting for individuals enrolled in the HCB Alternatives 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 licensed and regulated by the Department of Public Health, 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 HCB Alternatives 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.

Legal Authority and Requirements:

1. An ICF/DD-CN shall be licensed as an ICF/DD-N in accordance with 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.
2. An ICF/DD-CN must be contracted with a CMA, or in areas where there is no CMA 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.

Physical Plant and Health and Safety Requirements:

1. 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 contract or 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.
i. 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)].
ii. 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 Emergency Medical Technician (EMT) personnel, procedures for maintaining a record of participant movement and the method of sending all pertinent personal and medical 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.
iii. 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 a 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.

An ICF/DD-CN Providing Waiver Services:

1. 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 HCB Alternatives 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.

Nursing Services:

1. Sufficient RN and 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.
2. 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).
3. A minimum of one RN and one LVN in the facility and awake at all time.
4. 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.
5. Skilled nursing care includes, but is not limited to all of the following:
A. Assistance with ADLs and IADLs
B. Ventilator, tracheostomy and respiratory care
C. IV therapy
D. Feeding and elimination care (including tubes)
E. Medication administration
F. Skin care

Other Health Related Services:

1. 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.

2. 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 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.

Documentation:

1. All Waiver services rendered by the ICF/DD-CN shall require approval and reapproval.
2. 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 CMA or DHCS staff for any scheduled or unscheduled visit. All facility documentation shall be maintained in compliance with the applicable Federal and State laws, Medi- Cal, HCB Alternatives Waiver Provider Standards of Participation, and shall be retained by the facility for three years.
3. 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.

Quality Control/Quality Assurance:

1. Quality control/quality assurance reviews will be in accordance with the Quality Assurance Plan, as described in the approved waiver.

Training Requirements:

1. As a contracted or enrolled HCB Alternatives 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 a waiver provider and is not separately reimbursed by either Medi-Cal, the CMA or the waiver.
2. 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.
3. 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:

CDPH 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

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

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. HCB Alternatives 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:

1. Sufficient RN and 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.

2. 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 B&P Code section 2859.
3. A minimum of one RN or one LVN must be in the facility and awake at all times.
4. 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.
5. The following nursing care needs are included within the scope of continuous nursing:

• Assistance with ADLs and 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	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:
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
HCB Alternatives Waiver Standards of Participation (SOP)
Other Standard *(specify)*:
As an HCB Alternatives Waiver Service Provider, the ICF/DD-CN will provide a home-like setting for individuals enrolled in the HCB Alternatives 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 HCB Alternatives 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.

Legal Authority and Requirements:

1. An ICF/DD-CN shall be licensed as an ICF/DD-N in accordance with 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.
2. An ICF/DD-CN must be contracted with a CMA, or in areas where there is no CMA 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.

Physical Plant and Health and Safety Requirements:

1. 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 CDPH coordinator for review and approval.
i. 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)].
ii. 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.
iii. 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.

An ICF/DD-CN Providing Waiver Services:

1. 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 HCB Alternatives 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.

Nursing Services:

1. Sufficient RN and 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.
2. 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).
3. A minimum of one RN and one LVN in the facility and awake at all time.
4. 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.
5. Skilled nursing care includes, but is not limited to all of the following:
   A. Assistance with ADLs and IADLs
   B. Ventilator, tracheostomy and respiratory care
   C. IV therapy
   D. Feeding and elimination care (including tubes)
   E. Medication administration
   F. Skin care

Other Health Related Services:

1. 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.

2. 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 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.

Documentation:

1. All Waiver services rendered by the ICF/DD-CN shall require approval and reapproval.
2. 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 DHCS or CMA staff for any scheduled or unscheduled visit. All facility documentation shall be maintained in compliance with the applicable Federal and State laws, Medi- Cal and HCB Alternatives Waiver Provider SOPs, and shall be retained by the facility for three years.

3. 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.

Quality Control/Quality Assurance:

1. Quality control/quality assurance reviews will be in accordance with the Quality Assurance Plan, as described in the approved waiver.

Training Requirements:

1. As an enrolled HCB Alternatives 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 contracted or enrolled as a waiver provider and is not separately reimbursed by either Medi-Cal, the CMA or the waiver.
2. 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.
3. 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:
CDPH Licensing and Cerification Division
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:
Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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

All Environmental Accessibility Adaptations are subject to prior approval. 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 approved 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. Participant's current 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:
   A. An evaluation of the participant and the current equipment needs specific to the participant, describing how/why the current equipment does not meet the needs of the participant;
   B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the participant. This should also include information on the ability of the participant and/or the primary caregiver to learn about and appropriately use any requested item, and
   C. 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. 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;
4. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and,
5. 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 approval and reimbursement and a home visit has been conducted 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 CMT to explain to the participant the guidelines of the Environmental Accessibility Adaptation services under the waiver.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Environmental Accessibility Adaptation services are payable up to a total lifetime maximum amount of $5,000.00. The only exceptions to the $5,000.00 total maximum are if:

1. The recipient's place of residence changes or 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)*:

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

Specify whether the service may be provided by *(check each that applies)***:**
- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment (DME) Provider
Individual	HCBS Benefit Provider - Licensed Psychologist
Individual	HCBS Waiver Nurse Provider - RN
Agency	Non-Profit Agency
Agency	Professional Corporation
Agency	HHA
Individual	HCBS Benefit Provider - LCSW
Individual	HCBS Benefit Provider - MFT

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
CCR 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: 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.
CCR Title 16, §§1380 et seq.

Certificate *(specify):*

Other Standard *(specify):*

HCB Alternatives Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the HCB Alternatives Waiver, the role of a Licensed Psychologist as a direct Waiver Service Provider is to provide:

• Environmental Accessibility Adaptations (EAA)

A Licensed Psychologist who functions as an HCB Alternatives 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 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.
4. Provide case management services within the scope of practice of a Licensed Psychologist consistent with the participant's current primary care physician's orders and the POT as approved by the CMA or DHCS as follows:

A. Provide the participant's medically necessary case management services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT, if not acting as the care manager, of the participant's status which reflect the medical needs of the participant. Assist the participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice.

B. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.

i. The POT and supporting documents will be reviewed 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.

ii. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

C. Provide the HCB Alternatives Waiver EAA services as described on the participant's POT and as approved by the CMA or DHCS MC.

D. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 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: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - RN

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Under the HCB Alternatives Waiver, the role of the HCB Alternatives Waiver RN provider is to provide:

• Environmental Accessibility Adaptations (EAA)

"HCB Alternatives Waiver Nurse Provider" means a Registered Nurse who provides HCB Alternatives Waiver RN related services, as defined 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 HCB Alternatives Waiver population, a HCB Alternatives 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
• RN is on probation and have violated their probation conditions

An HCB Alternatives Waiver RN may be a parent, stepparent, foster parent of a participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers or CMAs. DHCS may require additional documentation to support requests of this nature. Documentation required before DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCB Alternatives 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 selected or refused employment, if offered.

"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.

"Evaluation of theoretical knowledge and manual skills" means an assessment conducted by the RN of the 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 prior to enrollment and when requested.

Requirements of the HCB Alternatives Waiver RN:

RN acting as the direct care provider:

1. The initial HCB Alternatives Waiver provider enrollment application shall be accompanied by all of the following documentation:
A. Current, unencumbered license to practice as an RN in the State of California.
B. Current BLS certification.
C. Written evidence, in a format acceptable to DHCS, of training or experience, which shall include at least one of the following:
i. 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 provider enrollment application. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.
ii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
iii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
iv. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specific to Waiver eligibility criteria on the provider enrollment application.

2. A detailed POT that reflects an appropriate nursing assessment of the waiver participant, interventions, and the participant's current primary care physician's orders.
3. 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).

4. The POT shall be signed by the waiver participant, the RN, and the waiver participant's current primary care physician, and shall contain the dates of service.
5. Signed release form from the waiver participant's current primary care physician, which shall specify both of the following:
A. The participant's current 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.

6. The participant's current primary care physician is willing to accept responsibility for the care rendered to the waiver participant.
7. Written home safety evaluation, in a format acceptable to the CMA or DHCS 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.

8. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's current primary care physician within the previous three months for an individual under the age of 21 and within the previous six months for an individual 21 years of age or older. If the last history and physical was completed outside of the respective timeframes, the history and physical shall be accompanied by documentation of the most recent office visit, which shall contain a detailed summary of medical findings that includes a body systems examination.
9. Annually the HCBS Waiver nurse provider shall submit the following documentation to the CMA or DHCS:
A. Evidence of renewal of BLS certification and unencumbered RN licensure prior to expiration.
B. Written evidence, in a format acceptable to DHCS, 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. Written evidence, in a format acceptable to DHCS, of on-going contact with the waiver participant's current primary care physician for the purpose of informing the participant's current primary care physician of the individual's progress, updating, and renewal of the participant's current primary care physician orders.

10. Evaluation of EAA services provided.
11. Written evidence of ongoing contact with the waiver participant's current primary care physician, as specified in "requirements of the HCB Alternatives 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:
Non-Profit Agency
Provider Qualifications
License *(specify):*
Business license, appropriate for the services purchased
Certificate *(specify):*

Other Standard *(specify):*
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 HCB Alternatives Waiver SOP and Provider requirements may provide HCB Alternatives Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following direct HCB Alternatives Waiver services:

• Environmental Accessibility Adaptations (EAA)

The Non-Profit Organization must provide EAA services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.
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:
Professional Corporation
Provider Qualifications
License *(specify):*
CC §13401(b)
Certificate *(specify):*

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide services approved under the HCB Alternatives 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 HCB Alternatives Waiver, the role of the Professional Corporation is to permit its licensed

employees within the scope of their practice to provide:

• Environmental Accessibility Adaptations (EAA)

A Professional Corporation must provide environmental accessibility adaptation services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS and/or CMA

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:

HHA

Provider Qualifications

License *(specify):*

HHA CCR Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR 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: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - LCSW

Provider Qualifications

License *(specify):*

BPC §§4990-4998.7
CCR Title 16, §§1870-1881

Certificate *(specify):*

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

An LCSW is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for an LCSW. Under the HCB Alternatives Waiver, the role of an LCSW as a direct HCB Alternatives Waiver Service Provider is to provide:

• Environmental Accessibility Adaptations (EAA)

An LCSW who functions as an HCB Alternatives Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as an 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 LCSW must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by the CMA and DHCS.
4. Provide the participant's medically necessary EAA services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT, if not acting as the care manager, of the participant's status which reflect the medical needs of the participant. Assist the participant in accessing medical care services that are beyond the LCSW's scope of practice.
5. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.
   A. The POT and supporting documents will be reviewed 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.
   B. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

6. Provide the HCB Alternatives Waiver EAA services as described on the participant's POT and as approved by the CMA or DHCS MC.
7. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 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 - MFT
Provider Qualifications
License *(specify):*
BPC §§4980-4989
Title 16, §§1829-1848
Certificate *(specify):*

Other Standard *(specify):*
An MFT is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for an MFT. Under the HCB Alternatives Waiver, the role of an MFT as an HCB Alternatives Waiver Service Provider is to provide:

• Environmental Accessibility Adaptations (EAA)

An MFT who functions as a direct HCB Alternatives Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as an 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.
4. Provide medically necessary case management services consistent with the participant's current primary care physician's orders and the POT as approved by the CMT if not the direct service provider, as follows:

A. Within the MFT's scope of practice, providing the waiver participant's medically necessary case management services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT if not the direct service provider of the waiver participant's status which reflect their medical needs. Assist the waiver participant in accessing medical care services that are beyond the MFT's scope of practice.
B. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.

i. The POT and supporting documents will be reviewed 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.
ii. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

C. Provide the HCB Alternatives Waiver EAA services as described on the participant's POT and as approved by the CMA or DHCS MC.
D. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 Board of Behavioral Sciences
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

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
The Facility Respite benefit services are provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant.

These services are provided in an approved out-of-home location to do all of the following:

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

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

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	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:
CLHF
Provider Qualifications
License *(specify):*
HSC §§1250et seq.
CCR Title 22, §§51246 et seq.
Certificate *(specify):*

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

As an HCB Alternatives Waiver Service Provider, the CLHF will provide a home like setting for individuals enrolled in the HCB Alternatives Waiver who chooses a CLHF as their place of respite. 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 or respite facility with a non- institutional, homelike environment, having no more than eighteen 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 participants shall be the availability of skilled nursing care on a recurring, intermittent, extended, or continuous basis.

Legal Authority and Requirements:

1. A CLHF shall be licensed in accordance with H&S 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 CCR Title 22 sections 51003 and 51344 and the waiver document.
2. A CLHF must be contracted or 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.
3. 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.

Physical Plant and Health and Safety Requirements:

1. 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 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 in a homelike and communal manner.
D. The 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.
E. Bathrooms of sufficient space and quantity shall be provided to allow for the hygiene needs of each respite participant 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.

A CLHF Providing Waiver Services:

1. 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 B&P Code and all the SOP of the HCB Alternatives Waiver. The primary category of service provided by a CLHF is nursing services, which must be available to Waiver clients on their individual care needs.

Nursing Services:

1. Pursuant to H&S Code section 1267.13(o)(2)(B) and (o)(2)(C), a CLHF shall provide nursing services provided by an RN, LVN, and an 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 participants 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. RN
i. An RN will be available on-call to the facility with a response time of thirty minutes or less at all times that an 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. LVN
i. An LVN shall be in the facility and "on duty" at any time that a RN is not in the facility.

C. CNA or equivalent unlicensed provider
i. An 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.

2. The facility shall provide appropriately qualified staff in sufficient numbers to meet patient care needs.

Other Health Related Services:

1. 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

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.

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."

As a Waiver service provider, each HCB Alternatives 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.

Documentation:

1. All Waiver services rendered by the CLHF shall require prior approval and reapproval in accordance with CCR Title 22, section 51003.
2. A TAR shall be prepared by the CLHF and submitted to the CMA for each waiver participant utilizing respite in a CLHF that renders Waiver services. The initial TAR for each waiver participant shall be accompanied by an RN developed assessment of care needs, and a POT signed by the participant's current 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.
3. Each CLHF shall maintain a medical record chart for each waiver participant. 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 the CMT for any scheduled or unscheduled visit. All CLHF documentation shall be maintained in compliance with the applicable Federal and State laws, HCB Alternatives Waiver 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 SOP have been met and have those records available for inspection or review by the CMT or DHCS upon request at any time a contracted or enrolled waiver participant is receiving services through a CLHF.

Quality Control/Quality Assurance:

1. 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.

Training Requirements:

1. 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, the CMA or the Waiver.
2. 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. CDPH 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.
3. 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:
CDPH 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

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

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 current 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 current primary care physician signed POT.

Family/Caregiver Training services in the participant's home may be provided only by an RN. 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 CMA/DHCS. Upon completion of the training, the provider will submit documentation of the training results to the CMA/DHCS.
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	HHA
Individual	HCBS Waiver Nurse Provider - 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:
HHA
Provider Qualifications
License *(specify):*
HHA CCR Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR 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: Other Service
Service Name: Family/Caregiver Training

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

Other Standard *(specify):*
Under the HCB Alternatives Waiver, the role of the HCB Alternatives Waiver RN provider is to provide:

• Family/Caregiver Training

"HCB Alternatives Waiver Nurse Provider" means a Registered Nurse who provides HCB Alternatives Waiver RN related services, as defined 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 HCB Alternatives Waiver population, a HCB Alternatives 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
• RN is on probation and have violated their probation conditions

An HCB Alternatives Waiver RN may be a parent, stepparent, foster parent of a participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers or CMAs. DHCS may require additional documentation to support requests of this nature. Documentation required before DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCB Alternatives 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 selected or refused employment, if offered.

"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.

"Evaluation of theoretical knowledge and manual skills" means an assessment conducted by the RN of the 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 prior to enrollment and when requested.

Requirements of the HCB Alternatives Waiver RN:

RN acting as the direct care provider:

1. The initial HCB Alternatives Waiver provider enrollment application shall be accompanied by all of the following documentation:
  A. Current, unencumbered license to practice as an RN in the State of California.
  B. Current BLS certification.
  C. Written evidence, in a format acceptable to DHCS, of training or experience, which shall include at least one of the following:
    i. 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 provider enrollment application. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.
    ii. 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) specific to Waiver eligibility criteria on the provider enrollment application.

iii. 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) specific to Waiver eligibility criteria on the provider enrollment application.

iv. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specific to Waiver eligibility criteria on the provider enrollment application.

2. A detailed POT that reflects an appropriate nursing assessment of the waiver participant, interventions, and the participant's current primary care physician's orders.
3. 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).
4. The POT shall be signed by the waiver participant, the RN, and the waiver participant's current primary care physician, and shall contain the dates of service.
5. Signed release form from the waiver participant's current primary care physician, which shall specify both of the following:

A. The participant's current 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.

6. The participant's current primary care physician is willing to accept responsibility for the care rendered to the waiver participant.
7. Written home safety evaluation, in a format acceptable to the CMA or DHCS 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.

8. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's current primary care physician within the previous three months for an individual under the age of 21 and within the previous six months for an individual 21 years of age or older. If the last history and physical was completed outside of the respective timeframes, the history and physical shall be accompanied by documentation of the most recent office visit, which shall contain a detailed summary of medical findings that includes a body systems examination.
9. Annually the HCBS Waiver nurse provider shall submit the following documentation to the CMA or DHCS:

A. Evidence of renewal of BLS certification and unencumbered RN licensure prior to expiration.

B. Written evidence, in a format acceptable to DHCS, 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. Written evidence, in a format acceptable to DHCS, of on-going contact with the waiver participant's current primary care physician for the purpose of informing the participant's current primary care physician of the individual's progress, updating, and renewal of the participant's current primary care physician orders.

10. Evaluation of family/caregiver training services provided.

11. Written evidence of ongoing contact with the waiver participant's current primary care physician, as specified in "requirements of the HCB Alternatives 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

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

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 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 the CMA for evaluation of the request. After the request has been approved, the waiver service provider may bill the CMA or 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 CMT is responsible for notifying the local utility providers that the HCB Alternatives 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 CMT.

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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	HCBS Benefit Provider - MFT
Agency	HHA
Individual	HCBS Benefit Provider - Licensed Psychologist
Agency	Professional Corporation
Agency	Non-Profit Agency
Individual	HCBS Waiver Nurse Provider - RN
Individual	HCBS Benefit Provider - LCSW

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 - MFT
Provider Qualifications
License *(specify):*
BPC §§4980-4989
Title 16, §§1829-1848
Certificate *(specify):*

Other Standard *(specify):*
An MFT is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for an MFT. Under the HCB Alternatives Waiver, the role of an MFT as an HCB Alternatives Waiver Service Provider is to provide:

• Medical Equipment Operating Expense (MEOE)

An MFT who functions as a direct HCB Alternatives Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as an 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.
4. Provide medically necessary case management services consistent with the participant's current primary care physician's orders and the POT as approved by the CMT if not the direct service provider, as follows:

A. Within the MFT's scope of practice, providing the waiver participant's medically necessary case management services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT if not the direct service provider of the waiver participant's status which reflect their medical needs. Assist the waiver participant in accessing medical care services that are beyond the MFT's scope of practice.
B. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.

i. The POT and supporting documents will be reviewed 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.
ii. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

C. Provide the HCB Alternatives Waiver MEOE services as described on the participant's POT and as approved by the CMA or DHCS MC.
D. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 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:
HHA
Provider Qualifications
License *(specify):*
HHA CCR Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR 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: 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.
CCR Title 16, §§1380 et seq.
Certificate *(specify):*

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the HCB Alternatives Waiver, the role of a Licensed Psychologist as a direct Waiver Service Provider is to provide:

• Medical Equipment Operating Expense (MEOE)

A Licensed Psychologist who functions as an HCB Alternatives 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 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.
4. Provide case management services within the scope of practice of a Licensed Psychologist consistent with the participant's current primary care physician's orders and the POT as approved by the CMA or DHCS as follows:

A. Provide the participant's medically necessary case management services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT, if not acting as the care manager, of the participant's status which reflect the medical needs of the participant. Assist the participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice.
B. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.

i. The POT and supporting documents will be reviewed 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.
ii. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

C. Provide the HCB Alternatives Waiver MEOE services as described on the participant's POT and as approved by the CMA or DHCS MC.
D. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 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:
Agency
Provider Type:
Professional Corporation
Provider Qualifications

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

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide services approved

under the HCB Alternatives 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 HCB Alternatives Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:

• Medical Equipment Operating Expense (MEOE)

A Professional Corporation must provide MEOE services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS and/or CMA

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:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify)*:

Business license, appropriate for the services purchased

Certificate *(specify)*:

Other Standard *(specify)*:

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 HCB Alternatives Waiver SOP and Provider requirements may provide HCB Alternatives Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following direct HCB Alternatives Waiver services:

• Medical Equipment Operating Expense (MEOE)

The Non-Profit Organization must provide MEOE services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.

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: Medical Equipment Operating Expense

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

Other Standard *(specify):*
Under the HCB Alternatives Waiver, the role of the HCB Alternatives Waiver RN provider is to provide:

• Medical Equipment Operating Expense (MEOE)

"HCB Alternatives Waiver Nurse Provider" means a Registered Nurse who provides HCB Alternatives Waiver RN related services, as defined 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 HCB Alternatives Waiver population, a HCB Alternatives 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
• RN is on probation and have violated their probation conditions

An HCB Alternatives Waiver RN may be a parent, stepparent, foster parent of a participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers or CMAs. DHCS may require additional documentation to support requests of this nature. Documentation required before DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCB Alternatives 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 selected or refused employment, if offered.

"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.

"Evaluation of theoretical knowledge and manual skills" means an assessment conducted by the RN of the 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 prior to enrollment and when requested.

Requirements of the HCB Alternatives Waiver RN:

RN acting as the direct care provider:

1. The initial HCB Alternatives Waiver provider enrollment application shall be accompanied by all of the following documentation:
A. Current, unencumbered license to practice as an RN in the State of California.
B. Current BLS certification.
C. Written evidence, in a format acceptable to DHCS, of training or experience, which shall include at least one of the following:
i. 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 provider enrollment application. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.
ii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
iii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
iv. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specific to Waiver eligibility criteria on the provider enrollment application.

2. A detailed POT that reflects an appropriate nursing assessment of the waiver participant, interventions, and the participant's current primary care physician's orders.
3. 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).
4. The POT shall be signed by the waiver participant, the RN, and the waiver participant's current primary care physician, and shall contain the dates of service.
5. Signed release form from the waiver participant's current primary care physician, which shall specify both of the following:
A. The participant's current 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.

6. The participant's current primary care physician is willing to accept responsibility for the care rendered to the waiver participant.
7. Written home safety evaluation, in a format acceptable to the CMA or DHCS 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.

8. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's current primary care physician within the previous three months for an individual under the age of 21 and within the previous six months for an individual 21 years of age or older. If the last history and physical was completed outside of the respective timeframes, the history and physical shall be accompanied by documentation of the most recent office visit, which shall contain a detailed summary of medical findings that includes a body systems examination.
9. Annually the HCBS Waiver nurse provider shall submit the following documentation to the CMA or DHCS:
A. Evidence of renewal of BLS certification and unencumbered RN licensure prior to expiration.
B. Written evidence, in a format acceptable to DHCS, 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. Written evidence, in a format acceptable to DHCS, of on-going contact with the waiver participant's current primary care physician for the purpose of informing the participant's current primary care physician of the individual's progress, updating, and renewal of the participant's current primary care physician orders.

10. Evaluation of MEOE services provided.
11. Written evidence of ongoing contact with the waiver participant's current primary care physician, as specified in "requirements of the HCB Alternatives 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 - LCSW
Provider Qualifications
License *(specify):*
BPC §§4990-4998.7
CCR Title 16, §§1870-1881
Certificate *(specify):*

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

An LCSW is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for an LCSW. Under the HCB Alternatives Waiver, the role of an LCSW as a direct HCB Alternatives Waiver Service Provider is to provide:

• Medical Equipment Operating Expense (MEOE)

An LCSW who functions as an HCB Alternatives Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as an 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 LCSW must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by the CMA and DHCS.
4. Provide the participant's medically necessary MEOE services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT, if not acting as the care manager, of the participant's status which reflect the medical needs of the participant. Assist the participant in accessing medical care services that are beyond the LCSW's scope of practice.
5. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.
A. The POT and supporting documents will be reviewed 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.
B. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

6. Provide the HCB Alternatives Waiver MEOE services as described on the participant's POT and as approved by the CMA or DHCS MC.
7. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 Board of Behavioral Sciences

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

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
The Personal Emergency Response System (PERS) installation and testing service is for installation and testing of a PERS for participants who are at high risk of institutionalization to secure help in the event of an emergency. Authorization is limited to participants 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:

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)***:**

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DME Provider
Agency	Non-Profit Agency
Individual	HCBS Benefit Provider - MFT
Individual	HCBS Waiver Nurse Provider - RN
Individual	HCBS Benefit Provider - Licensed Psychologist
Individual	HCBS Benefit Provider - LCSW
Agency	Professional Corporation
Agency	HHA

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:
DME Provider
Provider Qualifications
License *(specify):*
W&I 14043.15, 14043.2, 14043.25, 14043.26
CCR 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: 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):*
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 HCB Alternatives Waiver SOP and Provider requirements may provide HCB Alternatives Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following direct HCB Alternatives Waiver services:

• Personal Emergency Response (PERS) Installation and Testing

The Non-Profit Organization must provide PERS installation and testing services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.
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 (PERS) Installation and Testing

Provider Category:
Individual
Provider Type:
HCBS Benefit Provider - MFT
Provider Qualifications
License *(specify):*
BPC §§4980-4989
Title 16, §§1829-1848
Certificate *(specify):*

Other Standard *(specify):*
An MFT is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for an MFT. Under the HCB Alternatives Waiver, the role of an MFT as an HCB Alternatives Waiver Service Provider is to provide:

• Personal Emergency Response (PERS) Installation and Testing

An MFT who functions as a direct HCB Alternatives Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as an 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.
4. Provide medically necessary case maangement services consistent with the participant's current primary care physician's orders and the POT as approved by the CMT if not the direct service provider, as follows:

A. Within the MFT's scope of practice, providing the waiver participant's medically necessary case management services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT if not the direct service provider of the waiver participant's status which reflect their medical needs. Assist the waiver participant in accessing medical care services that are beyond the MFT's scope of practice.
B. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.

i. The POT and supporting documents will be reviewed 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.
ii. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval

of 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.

C. Provide the HCB Alternatives Waiver PERS installation and testing services as described on the participant's POT and as approved by the CMA or DHCS MC.

D. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 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:

Individual

Provider Type:

HCBS Waiver Nurse Provider - RN

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Under the HCB Alternatives Waiver, the role of the HCB Alternatives Waiver RN provider is to provide:

• Personal Emergency Response (PERS) Installation and Testing

"HCB Alternatives Waiver Nurse Provider" means a Registered Nurse who provides HCB Alternatives Waiver RN related services, as defined 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 HCB Alternatives Waiver population, a HCB Alternatives 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
• RN is on probation and have violated their probation conditions

An HCB Alternatives Waiver RN may be a parent, stepparent, foster parent of a participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers or CMAs. DHCS may require additional documentation to support requests of this nature. Documentation required before DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCB Alternatives 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 selected or refused employment, if offered.

"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.

"Evaluation of theoretical knowledge and manual skills" means an assessment conducted by the RN of the 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 prior to enrollment and when requested.

Requirements of the HCB Alternatives Waiver RN:

RN acting as the direct care provider:

1. The initial HCB Alternatives Waiver provider enrollment application shall be accompanied by all of the following documentation:
   A. Current, unencumbered license to practice as an RN in the State of California.
   B. Current BLS certification.
   C. Written evidence, in a format acceptable to DHCS, of training or experience, which shall include at least one of the following:
      i. 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 provider enrollment application. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.
      ii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
      iii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
      iv. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specific to Waiver eligibility criteria on the provider enrollment application.

2. A detailed POT that reflects an appropriate nursing assessment of the waiver participant, interventions, and the participant's current primary care physician's orders.
3. 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).
4. The POT shall be signed by the waiver participant, the RN, and the waiver participant's current primary care physician, and shall contain the dates of service.
5. Signed release form from the waiver participant's current primary care physician, which shall specify both of the following:
   A. The participant's current 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.

6. The participant's current primary care physician is willing to accept responsibility for the care rendered to the waiver participant.
7. Written home safety evaluation, in a format acceptable to the CMA or DHCS 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.

8. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's current primary care physician within the previous three months for an individual under the age of 21 and within the previous six months for an individual 21 years of age or older. If the last history and physical was completed outside of the respective timeframes, the history and physical shall be accompanied by documentation of the most recent office visit, which shall contain a detailed summary of medical findings that includes a body systems examination.
9. Annually the HCBS Waiver nurse provider shall submit the following documentation to the CMA or DHCS:
A. Evidence of renewal of BLS certification and unencumbered RN licensure prior to expiration.
B. Written evidence, in a format acceptable to DHCS, 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. Written evidence, in a format acceptable to DHCS, of on-going contact with the waiver participant's current primary care physician for the purpose of informing the participant's current primary care physician of the individual's progress, updating, and renewal of the participant's current primary care physician orders.

10. Evaluation of PERS installation and testing services provided.
11. Written evidence of ongoing contact with the waiver participant's current primary care physician, as specified in "requirements of the HCB Alternatives 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.
CCR Title 16, §§1380 et seq.
Certificate *(specify):*

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the HCB Alternatives Waiver, the role of a Licensed Psychologist as a direct Waiver Service Provider is to provide:

• Personal Emergency Response (PERS) Installation and Testing

A Licensed Psychologist who functions as an HCB Alternatives 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 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.
4. Provide case management services within the scope of practice of a Licensed Psychologist consistent with the participant's current primary care physician's orders and the POT as approved by the CMA or DHCS as follows:

A. Provide the participant's medically necessary case management services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT, if not acting as the care manager, of the participant's status which reflect the medical needs of the participant. Assist the participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice.
B. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.

i. The POT and supporting documents will be reviewed 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.
ii. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

C. Provide the HCB Alternatives Waiver PERS installation and testing services as described on the participant's POT and as approved by the CMA or DHCS MC.
D. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 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 - LCSW
Provider Qualifications
License *(specify):*
BPC §§4990-4998.7
CCR Title 16, §§1870-1881
Certificate *(specify):*

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

An LCSW is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for an LCSW. Under the HCB Alternatives Waiver, the role of an LCSW as a direct HCB Alternatives Waiver Service Provider is to provide:

• Personal Emergency Response (PERS) Installation and Testing

An LCSW who functions as an HCB Alternatives Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as an 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 LCSW must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by the CMA and DHCS.
4. Provide the participant's medically necessary PERS installation and testing services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT, if not acting as the care manager, of the participant's status which reflect the medical needs of the participant. Assist the participant in accessing medical care services that are beyond the LCSW's scope of practice.
5. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.
   A. The POT and supporting documents will be reviewed 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.
   B. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

6. Provide the HCB Alternatives Waiver PERS installation and training services as described on the

participant's POT and as approved by the CMA or DHCS MC.
7. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 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):*
HCB Alternatives Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide services approved under the HCB Alternatives 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 HCB Alternatives Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:

• Personal Emergency Response (PERS) Installation and Testing

A Professional Corporation must provide PERS installation and testing services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCS and/or CMA
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:
Agency
Provider Type:

HHA

Provider Qualifications

License *(specify):*

HHA CCR Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR 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: 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 Systems (PERS)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**

Service is not included in the approved waiver.

Service Definition *(Scope)*:
The 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 CMT.

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 - LCSW
Agency	DME Provider
Agency	Non-Profit Agency

Individual	**HCBS Waiver Nurse Provider - RN**
Individual	**HCBS Benefit Provider - Licensed Psychologist**
Agency	**HHA**
Individual	**HCBS Benefit Provider - MFT**
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 - LCSW
Provider Qualifications
License *(specify):*
BPC §§4990-4998.7
CCR Title 16, §§1870-1881
Certificate *(specify):*

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

An LCSW is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for an LCSW. Under the HCB Alternatives Waiver, the role of an LCSW as a direct HCB Alternatives Waiver Service Provider is to provide:

• Personal Emergency Response Systems (PERS)

An LCSW who functions as an HCB Alternatives Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as an 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 LCSW must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by the CMA and DHCS.
4. Provide the participant's medically necessary PERS services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT, if not acting as the care manager, of the participant's status which reflect the medical needs of the participant. Assist the participant in accessing medical care services that are beyond the LCSW's scope of practice.
5. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.
   A. The POT and supporting documents will be reviewed 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.
   B. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally

responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

6. Provide the HCB Alternatives Waiver PERS services as described on the participant's POT and as approved by the CMA or DHCS MC.
7. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 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:
DME Provider
Provider Qualifications

License *(specify):*
W&I 14043.15, 14043.2, 14043.25, 14043.26
CCR 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: 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):*
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 HCB Alternatives Waiver SOP and Provider requirements may provide HCB Alternatives Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following direct HCB Alternatives Waiver services:

• Personal Emergency Response System (PERS)

The Non-Profit Organization must provide PERS services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.

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:
Individual
Provider Type:
HCBS Waiver Nurse Provider - RN
Provider Qualifications

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

Other Standard *(specify):*
Under the HCB Alternatives Waiver, the role of the HCB Alternatives Waiver RN provider is to provide:

• Personal Emergency Response Systems (PERS)

"HCB Alternatives Waiver Nurse Provider" means a Registered Nurse who provides HCB Alternatives Waiver RN related services, as defined 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 HCB Alternatives Waiver population, a HCB Alternatives 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
• RN is on probation and have violated their probation conditions

An HCB Alternatives Waiver RN may be a parent, stepparent, foster parent of a participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers or CMAs. DHCS may require additional documentation to support requests of this nature. Documentation required before DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCB Alternatives 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 selected or refused employment, if offered.

"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.

"Evaluation of theoretical knowledge and manual skills" means an assessment conducted by the RN of the 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 prior to enrollment and when requested.

Requirements of the HCB Alternatives Waiver RN:

RN acting as the direct care provider:

1. The initial HCB Alternatives Waiver provider enrollment application shall be accompanied by all of the following documentation:
   A. Current, unencumbered license to practice as an RN in the State of California.
   B. Current BLS certification.
   C. Written evidence, in a format acceptable to DHCS, of training or experience, which shall include at least one of the following:
      i. 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 provider enrollment application. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.
      ii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
      iii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
      iv. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specific to Waiver eligibility criteria on the provider enrollment application.

2. A detailed POT that reflects an appropriate nursing assessment of the waiver participant, interventions, and the participant's current primary care physician's orders.
3. 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).
4. The POT shall be signed by the waiver participant, the RN, and the waiver participant's current primary care physician, and shall contain the dates of service.
5. Signed release form from the waiver participant's current primary care physician, which shall specify both of the following:
A. The participant's current 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.

6. The participant's current primary care physician is willing to accept responsibility for the care rendered to the waiver participant.
7. Written home safety evaluation, in a format acceptable to the CMA or DHCS 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.

8. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's current primary care physician within the previous three months for an individual under the age of 21 and within the previous six months for an individual 21 years of age or older. If the last history and physical was completed outside of the respective timeframes, the history and physical shall be accompanied by documentation of the most recent office visit, which shall contain a detailed summary of medical findings that includes a body systems examination.
9. Annually the HCBS Waiver nurse provider shall submit the following documentation to the CMA or DHCS:
A. Evidence of renewal of BLS certification and unencumbered RN licensure prior to expiration.
B. Written evidence, in a format acceptable to DHCS, 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. Written evidence, in a format acceptable to DHCS, of on-going contact with the waiver participant's current primary care physician for the purpose of informing the participant's current primary care physician of the individual's progress, updating, and renewal of the participant's current primary care physician orders.

10. Evaluation of PERS services provided.
11. Written evidence of ongoing contact with the waiver participant's current primary care physician, as specified in "requirements of the HCB Alternatives 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 Systems (PERS)

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

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the HCB Alternatives Waiver, the role of a Licensed Psychologist as a direct Waiver Service Provider is to provide:

• Personal Emergency Response System (PERS)

A Licensed Psychologist who functions as an HCB Alternatives 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 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.
4. Provide case management services within the scope of practice of a Licensed Psychologist consistent with the participant's current primary care physician's orders and the POT as approved by the CMA or DHCS as follows:

A. Provide the participant's medically necessary case management services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT, if not acting as the care manager, of the participant's status which reflect the medical needs of the participant. Assist the participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice.
B. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.

i. The POT and supporting documents will be reviewed 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.
ii. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

C. Provide the HCB Alternatives Waiver PERS services as described on the participant's POT and

as approved by the CMA or DHCS MC.

D. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 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:

Agency

Provider Type:

HHA

Provider Qualifications

License *(specify):*

HHA CCR Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR 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: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - MFT

Provider Qualifications

License *(specify):*

BPC §§4980-4989
Title 16, §§1829-1848

Certificate *(specify):*

Other Standard *(specify):*
An MFT is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for an MFT. Under the HCB Alternatives Waiver, the role of an MFT as an HCB Alternatives Waiver Service Provider is to provide:

• Personal Emergency Response System (PERS)

An MFT who functions as a direct HCB Alternatives Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as an 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.
4. Provide medically necessary case management services consistent with the participant's current primary care physician's orders and the POT as approved by the CMT if not the direct service provider, as follows:

A. Within the MFT's scope of practice, providing the waiver participant's medically necessary case management services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT if not the direct service provider of the waiver participant's status which reflect their medical needs. Assist the waiver participant in accessing medical care services that are beyond the MFT's scope of practice.
B. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.

i. The POT and supporting documents will be reviewed 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.
ii. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

C. Provide the HCB Alternatives Waiver PERS services as described on the participant's POT and as approved by the CMA or DHCS MC.
D. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 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:
Professional Corporation
Provider Qualifications
License *(specify):*
CC §13401(b)
Certificate *(specify):*

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide services approved under the HCB Alternatives 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 HCB Alternatives Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:

• Personal Emergency Response Systems (PERS)

A Professional Corporation must provide PERS services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHCS and/or CMA
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:
Private Duty Nursing - Including Home Health Aide and Shared Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
PDN services are individual and continuous care (in contrast to part-time or intermittent care) provided by a licensed nurse or a CHHA employed by a HHA 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:
The CMA or DHCS will not approve 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 IHSS, 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**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	HHA
Individual	HCBS Waiver Nurse Provider - LVN
Individual	HCBS Waiver Nurse Provider - RN

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:
HHA
Provider Qualifications
License *(specify):*
HHA Title 22, §§74659 et seq.
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: Other Service
Service Name: Private Duty Nursing - Including Home Health Aide and Shared Services

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

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

Under the HCB Alternatives Waiver, the role of the HCBS Waiver Nurse Provider – LVN is to provide:

• Private Duty Nursing (PDN)

Definitions:

"HCBS Waiver Nurse Provider – LVN" means an LVN who provides HCBS Waiver LVN services, as defined 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 HCB Alternatives Waiver population, an HCB Alternatives Waiver Nurse Provider application will not be processed, or a subcontract will not be entered into, 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
• LVN is on probation and have violated their probation conditions

A HCB Alternatives Waiver LVN may be a parent, stepparent, foster parent of the participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers or CMAs. DHCS may require additional documentation to support requests of this nature. Documentation required before DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCB Alternatives Waiver Nurse Provider, such as a posting classified advertisements for INP in the community and/or contacts with HHA, 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 selected or refused employment, if offered.

"HCBS Waiver LVN services" means private duty nursing services, as described the in HCB Alternatives 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 below, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

"Private duty nursing services" means services provided by an 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.

" 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. At the time of provider enrollment or subcontract, the application 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, of training or experience, as specified in "requirements of the HCBS Waiver LVN, above.

2. Annually the HCBS Waiver nurse provider shall submit the following documentation to the CMA or DHCS:
A. Evidence of renewal of BLS certification and unencumbered LVN licensure prior to expiration.
B. If services have been rendered within the last 12 calendar months, written evidence, in a format acceptable to DHCS, 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. If services have been rendered within the last 12 calendar months, a copy of the most recent POT that reflects the on-going CMT assessment and updated primary care physician orders. The POT shall be signed by the supervising RN, the waiver participant's current primary care physician, the waiver participant and the LVN, and shall contain the dates of service.

3. Evaluation of PDN services provided.
A. If services have been rendered within the last 12 calendar months, written evidence of ongoing

contact with the supervising RN, CMT and waiver participant's current primary care physician.

4. If private duty nursing is regularly scheduled, the HCBS Waiver LVN must notify the CMA or DHCS 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 DHCS.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Vocational Nursing and Psychiatric Technicians

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:

Individual

Provider Type:

HCBS Waiver Nurse Provider - RN

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Under the HCB Alternatives Waiver, the role of the HCB Alternatives Waiver RN provider is to provide:

• Private Duty Nursing (PDN)

Definitions:

"HCB Alternatives Waiver Nurse Provider" means a Registered Nurse who provides HCB Alternatives Waiver RN services, as defined 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 HCB Alternatives Waiver population, a HCB Alternatives Waiver Nurse Provider application will not be processed, or subcontract entered into, 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
• RN is on probation and have violated their probation conditions

An HCB Alternatives Waiver RN may be a parent, stepparent, foster parent of the participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers or CMAs. DHCS may require additional documentation to support requests of this nature. Documentation required before DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCB Alternatives Waiver Nurse Provider, such as a posting classified advertisements for Individual Nurse Providers in the community and/or contacts with HHAs, 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 selected or refused employment, if offered.

“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.

“Evaluation of theoretical knowledge and manual skills” means an assessment conducted by the RN of the 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 the CMA or DHCS, prior to enrollment or when requested.

Requirements of the HCB Alternatives Waiver RN:

RN acting as the direct care provider:

1. The initial HCB Alternatives Waiver provider subcontract or enrollment application shall be accompanied by all of the following documentation :
   A. Current, unencumbered license to practice as an RN in the State of California.
   B. Current BLS certification.
   C. Written evidence, in a format acceptable to DHCS, of training or experience, which shall include at least one of the following:

2. 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 provider enrollment application. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.
3. 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) specific to Waiver eligibility criteria on the provider enrollment application.
4. 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) specific to Waiver eligibility criteria on the provider enrollment application.
5. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specific to Waiver eligibility criteria on the provider enrollment application.
6. A detailed POT that reflects an appropriate nursing assessment of the waiver participant, interventions, and the participant’s current primary care physician’s orders.
7. The appropriateness of the nursing assessment and interventions shall be determined by the CMT based upon the waiver participant’s medical condition and care need(s).
8. The POT shall be signed by the waiver participant, the RN, and the waiver participant’s current primary care physician, and shall contain the dates of service.
9. Signed release form from the waiver participant’s current primary care physician, which shall specify both of the following:
   A. The participant’s current 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 participant's current primary care physician is willing to accept responsibility for the care rendered to the waiver participant.

10. Written home safety evaluation, in a format acceptable to the CMA or DHCS 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.

11. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's current primary care physician within the previous three months for an individual under the age of 21 and within the previous six months for an individual 21 years of age or older. If the last history and physical was completed outside of the respective timeframes, the history and physical shall be accompanied by documentation of the most recent office visit, which shall contain a detailed summary of medical findings that includes a body systems examination.
12. Annually the HCBS Waiver nurse provider shall submit the following documentation to the CMA or DHCS:
A. Evidence of renewal of BLS certification and unencumbered RN licensure prior to expiration.
B. Written evidence, in a format acceptable to DHCS, 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. Written evidence, in a format acceptable to DHCS, of on-going contact with the waiver participant's current primary care physician for the purpose of informing the participant's current primary care physician of the participant's progress, updating, and renewal of the participant's current primary care physician orders.

13. Evaluation of private duty nursing services provided.
14. Written evidence of ongoing contact with the waiver participant's current primary care physician, as specified in "requirements of the HCB Alternatives Waiver RN", above.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Board of Registered Nursing
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

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Transitional Case Management (TCM) services are provided to transition a Medi-Cal waiver eligible individual from a health care facility to HCBS. The CMT will have direct contact with the participant, his/her circle of support and the participant's current primary care physician to obtain information that will allow the CMT 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 89 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's cost allocation 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 CMT, 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 medically necessary medical and non-medical care needs, and plan on how the individual's needs are met.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
TCM services may be provided up to 89 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**
- [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
Individual	HCBS Benefit Provider - Licensed Psychologist
Individual	HCBS Benefit Provider - LCSW
Agency	Professional Corporation
Agency	HHA
Individual	HCBS Waiver Nurse Provider - RN
Agency	Non-Profit Agency
Individual	HCBS Benefit Provider - MFT

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.
CCR Title 16, §§1380 et seq.
Certificate *(specify):*

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

A Licensed Psychologist is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the HCB Alternatives Waiver, the role of a Licensed Psychologist as a direct Waiver Service Provider is to provide:

• Transitional Case Management (TCM)

A Licensed Psychologist who functions as an HCB Alternatives 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 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.
4. Provide case management services within the scope of practice of a Licensed Psychologist consistent with the participant's current primary care physician's orders and the POT as approved by the CMA or DHCS as follows:

A. Provide the participant's medically necessary case management services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the

CMT, if not acting as the care manager, of the participant's status which reflect the medical needs of the participant. Assist the participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice.

B. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.

i. The POT and supporting documents will be reviewed 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.

ii. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

C. Provide the HCB Alternatives Waiver TCM services as described on the participant's POT and as approved by the CMA or DHCS MC.

D. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 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: Transitional Case Management

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - LCSW

Provider Qualifications

License *(specify):*

BPC §§4990-4998.7
CCR Title 16, §§1870-1881

Certificate *(specify):*

Other Standard *(specify):*

HCB Alternatives Waiver Standards of Participation

An LCSW is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for an LCSW. Under the HCB Alternatives Waiver, the role of an LCSW as a direct HCB Alternatives Waiver Service Provider is to provide:

• Transitional Case Management (TCM)

An LCSW who functions as an HCB Alternatives Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as an 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 LCSW must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by the CMA and DHCS.
4. Provide the participant's medically necessary TCM services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT, if not acting as the care manager, of the participant's status which reflect the medical needs of the participant. Assist the participant in accessing medical care services that are beyond the LCSW's scope of practice.
5. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.
A. The POT and supporting documents will be reviewed 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.
B. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

6. Provide the HCB Alternatives Waiver TCM services as described on the participant's POT and as approved by the CMA or DHCS MC.
7. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 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:
Agency
Provider Type:
Professional Corporation
Provider Qualifications

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

Other Standard *(specify):*
HCB Alternatives Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide services approved

under the HCB Alternatives 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 HCB Alternatives Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:

• Transitional Case Management (TCM)

A Professional Corporation must provide TCM services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS and/or CMA

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:

HHA

Provider Qualifications

License *(specify):*

HHA CCR Title 22, §§74659 et seq.
CCR Title 22, §51067;
CCR 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: Other Service
Service Name: Transitional Case Management

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - RN

Provider Qualifications

License *(specify):*

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

Other Standard *(specify):*
Under the HCB Alternatives Waiver, the role of the HCB Alternatives Waiver RN provider is to provide:

• Transitional Case Management (TCM)

"HCB Alternatives Waiver Nurse Provider" means a Registered Nurse who provides HCB Alternatives Waiver RN related services, as defined 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 HCB Alternatives Waiver population, a HCB Alternatives 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
• RN is on probation and have violated their probation conditions

An HCB Alternatives Waiver RN may be a parent, stepparent, foster parent of a participant, a spouse, or legal guardian of the participant ONLY under the following circumstances: there are no other available providers or CMAs. DHCS may require additional documentation to support requests of this nature. Documentation required before DHCS can authorize such a request, is a written explanation of the attempts made to enlist and retain an HCB Alternatives 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 selected or refused employment, if offered.

"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.

"Evaluation of theoretical knowledge and manual skills" means an assessment conducted by the RN of the 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 prior to enrollment and when requested.

Requirements of the HCB Alternatives Waiver RN:

RN acting as the direct care provider:

1. The initial HCB Alternatives Waiver provider enrollment application shall be accompanied by all of the following documentation:
A. Current, unencumbered license to practice as an RN in the State of California.
B. Current BLS certification.
C. Written evidence, in a format acceptable to DHCS, of training or experience, which shall include at least one of the following:
i. 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 provider enrollment application. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.
ii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
iii. 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) specific to Waiver eligibility criteria on the provider enrollment application.
iv. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specific to Waiver eligibility criteria on the provider enrollment application.

2. A detailed POT that reflects an appropriate nursing assessment of the waiver participant, interventions, and the participant's current primary care physician's orders.
3. 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).
4. The POT shall be signed by the waiver participant, the RN, and the waiver participant's current primary care physician, and shall contain the dates of service.
5. Signed release form from the waiver participant's current primary care physician, which shall specify both of the following:
A. The participant's current 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.

6. The participant's current primary care physician is willing to accept responsibility for the care rendered to the waiver participant.
7. Written home safety evaluation, in a format acceptable to the CMA or DHCS 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.

8. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's current primary care physician within the previous three months for an individual under the age of 21 and within the previous six months for an individual 21 years of age or older. If the last history and physical was completed outside of the respective timeframes, the history and physical shall be accompanied by documentation of the most recent office visit, which shall contain a detailed summary of medical findings that includes a body systems

examination.
9. Annually the HCBS Waiver nurse provider shall submit the following documentation to the CMA or DHCS:
A. Evidence of renewal of BLS certification and unencumbered RN licensure prior to expiration.
B. Written evidence, in a format acceptable to DHCS, 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. Written evidence, in a format acceptable to DHCS, of on-going contact with the waiver participant's current primary care physician for the purpose of informing the participant's current primary care physician of the individual's progress, updating, and renewal of the participant's current primary care physician orders.

10. Evaluation of TCM services provided.
11. Written evidence of ongoing contact with the waiver participant's current primary care physician, as specified in "requirements of the HCB Alternatives 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:
Non-Profit Agency
Provider Qualifications

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

Other Standard *(specify):*
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 HCB Alternatives Waiver SOP and Provider requirements may provide HCB Alternatives Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified, professionally supervised unlicensed staff.

A Non-Profit Organization may provide the following direct HCB Alternatives Waiver services:

• Transitional Case Management (TCM)

The Non-Profit Organization must provide TCM services consistent with the participant's choice and interests, the participant's current primary care physician's orders and the HCB Alternatives Waiver POT within the licensed provider's scope of practice and/or the qualified professional's experience.

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:
Individual

Provider Type:
HCBS Benefit Provider - MFT

Provider Qualifications

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

Certificate *(specify)*:

Other Standard *(specify)*:
An MFT is an individual who is enrolled and provides services under the HCB Alternatives Waiver and who meets and maintains the SOP minimal qualifications for an MFT. Under the HCB Alternatives Waiver, the role of an MFT as an HCB Alternatives Waiver Service Provider is to provide:

• Transitional Case Management (TCM)

An MFT who functions as a direct HCB Alternatives Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as an 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.
4. Provide medically necessary TCM services consistent with the participant's current primary care physician's orders and the POT as approved by the CMT if not the direct service provider, as follows:

A. Within the MFT's scope of practice, providing the waiver participant's medically necessary TCM services at the scope, duration, and frequency described in the POT. Inform the participant's current primary care physician and the CMT if not the direct service provider of the waiver participant's status which reflect their medical needs. Assist the waiver participant in accessing medical care services that are beyond the MFT's scope of practice.
B. Submit the POT to the CMA or DHCS MC for approval of HCB Alternatives Waiver services.

i. The POT and supporting documents will be reviewed 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.
ii. Additional documentation supporting the medical necessity of the services described in the POT may be requested by the CMA or DHCS MC and any necessary or suggested revisions of the POT will be discussed with the provider. Modifications to the POT are made only with approval of the participant's current primary care physician, the participant and/or his/her legal representative/legally responsible adult(s). Enrollment in the HCB Alternatives Waiver or approval of 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.

C. Provide the HCB Alternatives Waiver TCM services as described on the participant's POT and as approved by the CMA or DHCS MC.

D. Facilitate the process of advocacy and/or mediation in the event that the participant's choice and interests are inconsistent with the participant's current 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 Board of Behavioral Sciences

Frequency of Verification:

Annually

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	
CLHF	
ICF-DD/CN	

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 CLHF enrolled as a waiver provider has up to eighteen beds with most approved waiver providers having 6 or less, with an option for a private unit. 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.

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. The resident also has the right to maintain access to food and controlling their own schedules. All CLHF residents sign a legally enforceable lease agreement with the residential setting provider.

For participants receiving services in CLHFs, the CMT or DHCS must determine that the setting is appropriate to the individual's need for independence, choice, autonomy, privacy and community integration. The person-centered process is always used to choose the services and settings and determine if the setting is appropriate to meet the individual's needs and choices and that the setting was selected by the participant from various other settings offered, including a non-disability specific setting. The determination will take into consideration the provision of the following:

1. Private or semi-private bedrooms shared by no more than two persons with personal décor. The choice of residential settings, including making decisions regarding sharing a bedroom, is made by the individual during the person-centered planning process.
2. Private or semi-private bathrooms. The residence must have enough bathroom space to ensure residents' privacy for personal hygiene, dressing, etc.
3. Common living areas or shared common space for interaction between residents, and residents and their guests.
4. Residents must have access to a kitchen area at all times.
5. Residents' opportunity to make decisions on their day-to-day activities, including visitors and when and what to eat, in their home and in the community.
6. Services which meet the needs of each resident.
7. Assurance of residents rights: a) to be treated with respect; b) choose and wear their own clothes; c) have private space to store personal items; d) have private space to visit with friends and family (if individuals choose to share a residence, visitors are allowed at any time, recognizing the rights of their roommates;) e) use the telephone with privacy; f) choose how and with whom to spend free time; and g) individuals can schedule and take part in community activities of their choice; h) residential units are accessible to the individual and have lockable entrance doors with appropriate staff having keys; and i) entering into an admission agreement and taking occupancy affords residents of licensed residential facilities the same protections from eviction that tenants have under landlord tenant law of the State, county, city or other designated entity.

The 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:

CLHF

Waiver Service(s) Provided in Facility:

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

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: Facility Specifications

Facility Type:

ICF-DD/CN

Waiver Service(s) Provided in Facility:

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

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: 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 participant, a spouse or legal guardian of a waiver participant, hereto referred to as legal representative/legally responsible adult, may provide select HCB Alternatives Waiver services.

The CMT will authorize the participant's legal representative/legally responsible adult to provide HCB Alternative's Waiver services upon evidence the legal representative/legally responsible adult:

1. In areas where there is no CMA, has an active Medi-Cal provider number with an 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 HCB Alternative's Waiver SOP; and
5. Provides evidence of the inability to select a local licensed professional who meets the service requirements in the participant's POT.

The evidence of inability to select a local licensed professional must document that:

1. There are no available providers;
2. There are no CMAs;
3. The participant lives in a remote or rural area experiencing shortages of licensed professionals;
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 HCB Alternative's Waiver provider standards may provide the following HCB Alternative's Waiver services:

- Case Management;
- Community Transition Services;
- Environmental Accessibility Adaptations;
- Family Training;
- Private Duty Nursing;
- Habilitation Services;
- Respite Home;
- PERS Installation and Testing;

• PERS;
• Transitional Case Management; and
• Medical Equipment Operating Expense.

DHCS 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 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 (in areas where there are no CMAs) and HCB Alternative's Waiver provider qualifications. Licensed providers must demonstrate they meet applicable state licensure requirements. Non-licensed providers must demonstrate they have the necessary skills to provide services as described on the POT. Information on how interested providers can become an HCB Alternative's Waiver provider is available online at the Medi-Cal website under Services, then Long-Term Care Alternatives. Provider enrollment information is also available in the Medi-Cal Provider Manual, provided at statewide DHCS presentations, and available on request by calling the DHCS Sacramento or Los Angeles office or calling the local CMA. The HCB Alternative's Waiver SOP are included in this waiver application.

In areas where a CMA is not available, DHCS has developed a provider information packet for licensed providers that will include:

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

Providers, in areas where there are no CMAs, first must apply for and receive a National Provider Identifier (NPI) number to include on the Medi-Cal Provider Application forms. When that number is received the provider is instructed to return the completed provider application to DHCS. DHCS reviews the application to determine if the provider meets the waiver's SOP and Medi-Cal provider requirements. Upon approval, DHCS provides a category of service code that allows them to render and be reimbursed for HCB Alternative's Waiver services.

Under the contract with DHCS, CMAs must establish and implement policies and procedures for assuring that all willing and qualified providers have the opportunity to contract as waiver service providers. CMAs must subcontract with a sufficient number of service providers to allow participant choice of providers for each service, when possible, and with other qualified providers desired by the participant. In compliance with Section 1902(a)(23) of the Social Security Act, waiver participants are given the choice of any qualified provider who agrees to furnish the services. DHCS monitors this requirement during the CMA QARs and CMA submission of subcontract information in quarterly progress reports.

Under the contract with DHCS, CMAs must recruit service providers on an ongoing basis and at least

annually. DHCS staff reviews and discusses provider recruitment efforts with CMAs during their biennial QAR onsite reviews.

Annually, CMAs verify the subcontracted provider of waiver services continues to meet waiver provider requirements through onsite provider visits. DHCS verifies non-licensed providers continue to meet waiver provider requirements at the point of provider enrollment and as necessary through the Case Management Information Payrolling System (CMIPSII).

In areas where there are no CMAs, annually, DHCS verifies that the provider of waiver services continues to meet the waiver program requirements through onsite provider visits. DHCS verifies non-licensed providers continue to meet waiver provider requirements at the point of provider enrollment and as necessary through CMIPSII.

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

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by 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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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 HCB Alternatives Waiver providers that were evaluated for compliance with all Federal and State waiver requirements during a timely annual visit by the CMA.

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:
Percent of HCB Alternatives Waiver provider records that has documentation of completed training within the last 12 months identifying the care needs of the participant.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(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:

Performance Measure:
Percent of HCB Alternatives Waiver provider records that have the provider's current license and/or certificate and/or meet the Waiver provider standards as required for each provider type in Appendix C-3.

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 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 non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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 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:

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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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 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 HCB Alternatives Waiver provider records that has documentation of completed training within the last 12 months identifying the care needs of the 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** 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:

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.
DHCS assures that the waiver services delivered to HCB Alternatives Waiver participants are provided by qualified waiver providers. DHCS requires that all providers meet HCB Alternatives Waiver Standards of Participation for each provider type, sign a Waiver Provider Agreement, and meet any California licensing and certification requirements prior to providing services to waiver participants. Documentation of current licenses and training are maintained at the CMA offices.

Provider performance is monitored by the CMA on an annual basis. Should deficiencies be reported to DHCS or discovered during the annual provider visit the CMA 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 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 CMA 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 DHCS.

DHCS uses the Quality Assurance Review to aggregate data gathered during the biennial Provider Record Review to analyze statewide trends and provide problem resolution with technical assistance and training to the CMA, when necessary.

Within 30 days of the Provider Record Review, DHCS will present an analysis of the findings to the CMA. Based upon the findings and level of compliance, remediation actions will be developed and implemented within 30 days by the CMA. DHCS will follow up on the effectiveness of any remedial action within 30 days. Remedial actions will be re-evaluated at the next Quality Assurance 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.

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 C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

For information regarding the Waiver specific transition plan, please refer to Attachment #2 in this application.

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)**
- [ ] **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:*

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 CMT. 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 the CMT. The CMT reviews 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 in the participant's condition. 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.

The CMT 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 but will provide comprehensive care management at the request of the waiver participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support. 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 CMT reviews the POT with the waiver 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 medically necessary care needs, type and duration of services, and providers of the service. In signing the POT, the participant's current primary care physician is attesting to the medical necessity of the waiver services identified in the POT.

The CMT is available to assist the waiver participant and/or his/her legal representative/legally responsible adult (s) and/or circle of support with information on local non-Medi-Cal, 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 CMT provides training to HCBS waiver providers, who assist the waiver participant in the development of his/her POT, on the waiver requirement to include the waiver 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 waiver participant's initial assessment, in the HCBS Informing Notice that is mailed to the HCBS waiver provider, and during the annual provider visit.

Beginning with the application for waiver services and throughout the development of the POT, the waiver 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 waiver 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 waiver participant's, his/her primary caregiver's, the participant's current primary care physician, HCBS waiver service providers, the CMA, if applicable, and the CMT's roles and responsibilities in the development and implementation of the POT.

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.

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 IPP. For children age 0 to 36 months old, this process is called the 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. ISP – ICF/DD-CN

Regulations in Title 22, CCR, Section 76860, state in part that an 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 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.

The CMT 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 but will provide

comprehensive care management at the request of the waiver participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support. 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 CMT reviews the POT with the waiver 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 medically necessary care needs, type and duration of services, and providers of the service. In signing the POT, the participant's current primary care physician is attesting to the medical necessity of the waiver services identified in the POT.

The CMT is available to assist the waiver participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support with information on local non-Medi-Cal, 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 CMT provides training to HCBS waiver providers, who assist the waiver participant in the development of his/her POT, on the waiver requirement to include the waiver 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 waiver participant's initial assessment, in the HCBS Informing Notice that is mailed to the HCBS waiver provider, and during the annual provider visit.

Beginning with the application for waiver services and throughout the development of the POT, the waiver 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 waiver 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 waiver participant's, his/her primary caregivers, the participant's current primary care physician, HCBS waiver service providers, the CMA, if applicable, and the CMA's roles and responsibilities in the development and implementation of the POT.

Participants served under the HCB Alternatives 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 by the CMA or DHCS. The CMT will assist the participant and/or legal representative/legally responsible adult in identifying a back-up caregiver. Back-up caregivers may 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 POT. The POT must be signed by the participant's current primary care physician, designated physician assistant or nurse practitioner (herein referred to as "participant's current primary care physician"). For purposes of the HCB Alternatives Waiver, the participant's current primary care physician is the physician that oversees the participant's home program and determines the medical necessity of the listed waiver services. In order for a back-up caregiver to be paid, they must be enrolled as a waiver provider.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

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):

1. The waiver case manager/coordinator is responsible for developing the POT. A waiver case manager/coordinator

can be:

A. In areas where there is a CMA:

• An RN licensed to practice in the State of California, who is under the direction of the participant's current primary care physician.
• A Physician licensed to practice in the State of California who is the participant's current primary care physician.

• LCSW or MSW.

B. In areas where there is no CMA:

• An RN licensed to practice in the State of California, who is under the direction of the participant's current primary care physician.
• A Physician licensed to practice in the State of California who is the participant's current primary care physician
• An MFT, Licensed Clinical Psychologist, or LCSW.

DHCS policies and procedures require that the participant's CMT 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, medically necessary waiver services, and providers in the development of the POT.

The participant's CMT 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 CMT, consulting with the waiver participant's current primary care physician, must update and obtain the current primary care physician-signed POT. "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.

In areas where there are no CMAs and the waiver participant's only service is WPCS then the waiver 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. Waiver service providers are required to submit a copy of the waiver participant's current primary care physician-signed POT with each request for authorization of WPCS services. The CMT monitors the timeliness of the WPCS only POT.

2. The CMT 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. In areas where there are no CMAs and the waiver participant's only service is WPCS then the waiver participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support will utilize the "Long-Term Care Division, In-Home Operation's, Plan of Treatment". The POT must include the participant's demographic information; treating and current 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 CMT completes the POT summarizing the health and functional status of the waiver participant during the previous POT period and the effectiveness of the services provided. The waiver participant, and/or his/her legal representative/legally responsible adult(s), the current primary care physician, and all providers of waiver services sign the completed POT.

The CMT 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 CMT's review of the POT is conducted during the initial request for HCB Alternatives Waiver services, during the reevaluation of the participant's LOC, at the annual provider visit, and with each request for waiver services. The CMT 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 participant's current 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 participant's current primary care physician.

3. The CMT provides information to the participant and/or his/her legal representative(s), and/or circle of support on the HCB Alternatives Waiver and available provider
types. This information is provided verbally during the initial and subsequent home visits, and in writing though the 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 the CMT in the development of a home care program, and to ensure the home program meets the HCB Alternatives Waiver 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 CMT when they have questions regarding waiver services and/or providers.
4. 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 CMT reviews the effectiveness of meeting the goals described in the POT during the LOC reevaluation home visit. In signing the POT, the primary care physician is attesting to the medical necessity of the waiver services identified in the POT.

The CMT is primarily responsible for assisting the participant with coordination of waiver and State Plan services, identify local resources provided by non-governmental organizations or state and local government agencies for transportation, housing, and nutrition services.

5.The CMT 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 CMT can assist the participant and/or his/her legal representative/legally responsible adult(s) and/or members of the circle of support with identifying providers, or other necessary services.
6. The POT requires the CMT, to identify waiver services, waiver providers, and the amount and frequency of waiver services. The CMT is responsible for making certain that services are provided in accordance with the POT. The CMT, reviews the POT while conducting the LOC reevaluation. During the reevaluation, the CMT, 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 CMT, is required to be present during the participant's scheduled reevaluation. Annually, the CMT conducts the provider visit,; the team reviews the participant case record and the participant's home program, including implementation of the elements of the POT. The CMT, together with the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support, prepares a plan for correction for issues identified during the reevaluation or the annual provider visit.
7. During care management contact/activities, if it is determined that the POT does not reflect the participant's medical needs due to significant changes in the participant's condition, the CMT must consult with the participant's current primary care physician, and update or revise the POT. "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 CMT. 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 the CMT or DHCS. The CMT, reviews 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 CMT's nursing evaluation and proposed interventions enabling the participant to live safely at home in the community. The CMT reviews the POT, taking into account the participant's medical condition and medically necessary care need(s), and signs and verifies the POT is signed by the service provider(s) and the participant's current primary care physician. The participant's current primary care physician's signature is evidence that he/she has reviewed the POT, agrees that it addresses all of the participant's medically necessary health care needs so that he/she can live safely at home or 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 CMT 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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

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 HCB Alternatives Waiver can select any provider who is qualified and willing to contract with the CMA and provide State Plan or waiver services. In areas where there is no CMA, participants receiving services through the HCB Alternatives 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 CMT 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 become a waiver provider. Additionally, the CMT 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 who can best meet his/her medically necessary 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 CMT, participant's other caregivers and the participant's current primary care physician. When requested by the participant and/or legal

representative/legally responsible adults, the CMT 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 options for settings in which they can reside. The participant is presented with the options available with a discussion of the similarities and distinctions between the setting types. CMTs are required to provide information, both oral and written to ensure that the participants have the information they require to make an informed choice.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

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 MC is responsible for approving the initial POT, which must be current, signed and submitted to DHCS at the time of requested waiver enrollment. POTs not meeting the HCB Alternatives Waiver standards are returned to the CMT, with instructions regarding needed revisions or additional information required. The revised POT must be sent to the participant's current primary care physician for review and signature prior to resubmission to the DHCS MC. The revised POT should accurately reflect the participant's medically necessary health care needs, services, providers, goals, and identifies and corrects safety issues prior to enrollment in the HCB Alternatives Waiver or approval for requested waiver services. After DHCS approval of initial waiver enrollment, the CMT 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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

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):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☑ **Other**

Specify:

CMA

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 CMT, is 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 CMT ensures 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 CMT is responsible for apprising the DHCS MC of the participant's status and reporting any unforeseen issues or problems that could negatively affect the participant.

The CMT is responsible for maintaining participant case notes documenting the participant's health status and identified problems and issues. The CMT 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 MC frequently reviews the CMT'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 CMT asks if they are satisfied with the plan of correction and resolution.

At the home visit, the CMT 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 participant's current primary care physician. Copies of the current and past POTs are filed in the participant's case record.
• Verify the participant is receiving the services described in the POT, review the POT with the participant and/or his/her legal representative/legally responsible adults and/or members of his/her circle of support and discuss the recommendations for waiver and non-waiver services and providers of services.
• Ensure the POT meets the participant's medically necessary health care needs and personal goals. During the on-site home visit the CMT assesses 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 medical necessity for the waiver services described in the POT.
• Review the back-up plan in the event a provider is not available. The CMT 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 instructed and understand 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.

The CMT will discuss identified problems or deficiencies in the POT with 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 current primary care physician, before additional waiver services and/or continued enrollment in the HCB Alternatives Waiver can be authorized. Health and safety issues described in the POT are documented using the Event/Issue Report and included in the participant's case record.

Upon enrollment into the HCB Alternatives Waiver, the CMT 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 DHCS approval for participant enrollment and the participant begins receiving waiver services, the CMT conducts a home visit to assess how the participant is coping. The CMT 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 medically necessary health care needs.

The level of case management acuity system is used by the CMT 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 CMT maintains regular contact with the participant. 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, the CMT should update the POT to reflect changes in the participant's medically necessary health care needs, waiver providers, and/or the delivery of waiver services.

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

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 assessed medically necessary care 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 medically necessary care 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**	☑ **Annually**

Specify:	
	☐ **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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 current primary care physician thereby indicating that the primary care physician agrees that the services meet the participant's medically necessary care 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**	☐ **Other**

	Ongoing	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 the Care Management Team and all waiver service providers thereby indicating that all waiver providers understand the services to be provided to the waiver participant.

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 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 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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 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 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:

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 with documentation by the Care Management Team 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:

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 HCB Alternatives 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 current primary care physician describing their responsibilities.

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

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(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 MOHS that identifies choice amongst services and provider types.

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.
DHCS assures that:

• The waiver participant and/or their circle of support are involved in identifying and managing the waiver services that meet the waiver participant's medically necessary care needs, and helping to ensure that the participant is satisfied with how those services are being delivered;
• The current primary care physician is in agreement that the participant is receiving the medically necessary waiver services to remain safely at home;
• The waiver service providers deliver those services as described on the participant's POT;
• The participant has been informed they have a choice to receive care in their home in lieu of facility care; and,
• The participant, the current primary care physician and waiver providers have been informed of their rights and responsibilities under the waiver.

DHCS is responsible for discovery activities as well as analyzing the data collected during those activities. DHCS will evaluate the findings discovered during monitoring and oversight activities and implement any remediation actions necessary to enhance, correct, and/or improve compliance with waiver assurances.

DHCS utilizes the following tools for discovery:

• Internet-based Case Management Information System (CMIS) and subsequently MedCompass;
• Care Management Onsite Review;
• Quality Assurance Reviews;
• Case Record Review;
• Provider Onsite Visit Review;
• Quarterly Utilization Reports;
• Event/Issue Database (will be integrated in to MedCompass);
• California Medicaid Management Information System (CA-MMIS);
• California Department of Social Services Case Management Information Payrolling System II (CMIPSII); and,
• Management Information and Decision Support System (MISDSS)

MedCompass is a database scheduled to be implemented in 2017. DHCS will use information from MedCompass to establish quality indicators that will help determine if changes need to be made to the waiver enrollment criteria, care management functions, services, providers, or any other aspect of waiver administration. MedCompass will 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. MedCompass will also capture data on applicants who are placed on the waitlist and tracks the reasons active waiver cases are closed. MedCompass will also allow the CMT to document the utilization and cost of WPCS, as well as track Notice of Actions (NOA) and capture the number of requests for State Fair Hearings along with the outcomes of those Fair Hearings. Until MedCompass is live DHCS will utilize CMIS for all of the activities listed above.

DHCS is responsible for conducting biennial onsite CMA Quality Assurance Reviews (QARs) and, in areas where there is no CMA, DHCS clinical reviews which will consist of Case Record Reviews on active HCB Alternatives 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. DHCS 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, DHCS selects the cases for review based upon the corresponding percentage of participants at each level of care (LOC) by the CMT. During the onsite QAR, the Case Record Review uses a tool designed to document the following:

• Evidence of the LOC evaluation;
• Evidence that 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 that the POT addresses all the participant's identified medically necessary care needs and assists in assuring the participant's health and welfare;
• Evidence that 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 that the POT reflects that all the participant's medically necessary services are planned and implemented in accordance with their unique medically necessary care 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; and
• Evidence that the CMT is completing and maintaining the waiver participant's case report in compliance with DHCS or the CMA's policies and procedures.

The DHCS Event/Issue database, which will be a part of MedCompass, 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.

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 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.

HCB Alternatives Waiver participants or their legal representative have the opportunity to select and dismiss licensed and unlicensed care 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 for the participant to select, dismiss and direct the services of their individual waiver providers, supports the participants':

• Freedom of choice in the provider of waiver services;
• Flexibility in scheduling the services to meet the participant's medically necessary care needs;
• Continuity of care; and
• Ability to direct the services that meet the participant's medically necessary care needs.

The CMT provides information on the availability of this option to the participant or legal representative at the face-to-face intake assessment and reassessment visits. The CMT advises the participant or legal representative on the roles and responsibilities for the participant or legal representative, participant's current primary care physician, DHCS, the CMA, and the provider of waiver services. Upon request, the CMT 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 WPCS and/or Respite Care services can select an unlicensed adult who is not the spouse, or legally responsible adult, parent, step-parent, or foster parent of a participant and is enrolled with the county's DSS IHSS program as a Personal Care Service (PCS) provider.

Participants or legal representatives may select individual licensed providers to provide the following waiver services:

• Case Management, in areas where there is no CMA
• Habilitation Services
• Community Transition Services, in areas where there is no CMA
• Private Duty Nursing
• Transitional Case Management, in areas where there is no CMA
• Family Training
• Respite Care

Participants or legal representative may select 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 CMA or county's IHSS program, licensed providers from the CMA or DHCS, or they can select an unlicensed or licensed provider who is not yet enrolled as a provider. Upon selecting an unlicensed or licensed provider that is not currently enrolled as a waiver provider, the CMA or DHCS will advise the potential provider of the subcontracting or 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 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 services to meet the needs of the participant. This training can come from the participant or the participant's legal representative, participant's current primary care physician or medical team, which may include clinical staff from the participant's current primary care physician's office or other specialists, the CMA, and other licensed providers that may be rendering waiver services. The CMT will document that the unlicensed provider has the knowledge, skills and abilities to meet the care needs of the participant.

Prior to rendering care, licensed providers that have been selected by the participant or legal representative must submit to the CMA or DHCS the required documentation that is described in the SOP for the individual's provider type. The CMT will document that the licensed provider has the experience to provide the care as described in the participant's POT.

The CMT 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 CMR. Any identified issues with the delivery of waiver service(s) by the unlicensed or licensed provider will be discussed and remediated with the participant or legal representative. The CMT will

interview the participant or legal representative as to the effectiveness of the remedial action. In the event issues affect or may affect the health and safety of the participant, the CMT will complete an Event/Issue Report, contact the participant's current primary care physician and the appropriate law enforcement, child or adult protective services, as applicable.

The CMT instructs the participant or legal representative to notify the CMA or DHCS 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, the CMA notifies the participant's current 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 are enrolled to work under the direction of the participant or legal representative and is not an employee of an organization or agency.

The CMA and DHCS must be in receipt of a current POT. The current POT must describe all the waiver and non-waiver services the participant receives, who provides those services, and is signed by the participant or legal representative, the participant's current primary care physician overseeing the participant's home program, the CMT who prepared the POT, and the signatures of all unlicensed and/or licensed waiver providers; 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 participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

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.

The CMT 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 HCB Alternatives Waiver Informing Notice and the MOHS.

If the participant or legal representative expresses interest in selecting an unlicensed provider to provide WPCS and/or Respite services, the CMT provides the participant with a Waiver Personal Care Information Packet which describes the roles and responsibilities of the participant, legal representative, the participant's current primary care physician, the CMTS 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 and Waiver Personal Care services;
• Waiver services can only be authorized upon the CMA or DHCS 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 the CMA or DHCS upon the selection and dismissal of providers.

If the participant or legal representative selects a licensed provider to provide case management only in areas where there is no CMA, PDN, medical equipment operating expenses family training and/or respite care services, the CMA or DHCS 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 participant's current primary care physician-signed POT; and
• The participant or legal representative is responsible for notifying the CMA or DHCS upon the selection 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.

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

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 services assists the participant in developing the POT, which is reviewed and signed by the participant's current primary care physician. The CMA or DHCS must have a participant's current primary care physician signed-POT prior to approval 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
Medical Equipment Operating Expense	☐
Facility Respite	☐
Private Duty Nursing - Including Home Health Aide and Shared Services	☐
Community Transition Services	☑
Habilitation Services	☑

Transitional Case Management	☑
Personal Emergency Response Systems (PERS)	☐
Home Respite	☐
Continuous Nursing and Supportive Services	☐
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	☐
Family/Caregiver Training	☐
Personal Emergency Response (PERS) Installation and Testing	☐
Waiver Personal Care Services (WPCS)	☐
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	☐
Case Management/Coordination	☐
Environmental Accessibility Adaptations	☐

☑ **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:

In areas where a CMA is not available, DHCS 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 MOHS. Upon enrollment in the waiver, the participant is assigned a DHCS RN.

The DHCS RN advises the participant or legal representative of the option of selecting participant direction services and providers at each reassessment visit 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 CMR and copies of the Informing Notice and MOHS is filed in the participant's case record.

At each participant's 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 CMR.

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 of any issues or problems and to notify the appropriate law enforcement agency, child or adult protective services, county IHSS office and/or licensing board in the event of abuse, neglect and/or exploitation. Only the participant or legal representative has the ability to select 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:

HCB Waiver Alternatives participants can elect to terminate participant direction services at any time. The participant or legal representative is advised to call the participant's assigned CMT upon the decision to terminate services. The CMT will provide the participant or legal representative with a list of alternate waiver providers to select from and update the POT accordingly. Upon the participant's identification of an alternative provider the CMT will work with the existing provider and new provider in transitioning the waiver services to ensure there is no break in waiver services. The POT must be reviewed and signed by the participant or legal representative, the participant's current primary care physician, the CMT, and the providers of wavier services, if applicable.

If the participant or legal representative is unable to secure an alternative waiver provider, the CMT will offer to transition the participant to a licensed medical facility until a new waiver provider is 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 provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The CMA or DHCS may elect to terminate authorization of participant directed services for the following reasons:

• Lack of a participant's current primary care physician-signed POT describing all the participant's 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; and
• 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 waiver services will only occur after all attempts by the CMA or DHCS to train and inform the participant or legal representative about the roles, responsibilities, and requirements of participant directed services have been exhausted or the participant or legal representative refuses to receive training on selecting and managing their providers.

The CMA or DHCS will provide the participant or legal representative with a NOA informing him/her of the decision to terminate 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	4174	
Year 2	5174	
Year 3	6174	
Year 4	7174	
Year 5	8174	

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*:

☑ **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:

DSS acts as a common law employer. Unlicensed providers must enroll as an IHSS provider at the county's DSS office. Payment for WPCS is processed through DSS' CMIPS II.

☐ **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*:

☑ **Recruit staff**
☑ **Refer staff to agency for hiring (co-employer)**
☑ **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 HCB Alternatives Waiver participants and/or his/her legal representative/legally responsible adult(s) of the opportunity to request a fair hearing to appeal a decision regarding waiver enrollment or waiver services is provided in two (2) pre-printed DHCS 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 the CMA and/or DHCS.

The CMA or DHCS 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 participant's current 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 the CMA or DHCS' 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 DSS 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 CMA or DHCS.

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, the CMA or DHCS 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 CMA or 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, the CMA or DHCS 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.. The CMA or DHCS 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 the CMA or DHCS' 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, each alone or in conjunction with each other, for issuing a NOA affecting the participant's enrollment in or benefits received under the waiver:

• The participant loses Medi-Cal eligibility;
• There is no evidence establishing the medical necessity of the requested waiver services;
• The participant moves from the geographical area in which the HCB Alternatives Waiver services were being authorized to a new area where there is no CMA, but there are providers of services, but no provider has agreed to render waiver services to the participant;
• In areas where there is no CMA, 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 medically necessary services and supports 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 participant's current primary care physician's orders on the POT, and the CMA or DHCS 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 a 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 CMA or DHCS 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 CMA, or in areas where there is no CMA an 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), DHCS 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 and/or any failure to comply with all regulatory requirements;
• A Participant is found to be a threat or harm to others they are residing with, including but not limited to caregivers or service providers, care managers or the community at large; or are unable to safely integrate into social settings to ensure the health and safety of the circle of support around the Participant;
• 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 WPCS, and does not have two (2) or more personal care providers to protect the safety of the participant;
• In areas where there is no CMA, the participant, legal representative/legally responsible adult(s), participant's current primary care physician, or waiver service provider has not submitted to DHCS a complete and current POT that is signed by the participant's current primary care physician, within 90 days of notification that he/she is eligible for enrollment in the HCB Alternatives Waiver or within 60 days of the end-date of the previous POT;
• The CMA or DHCS has not authorized a waiver service within 90 days of notification that the participant is eligible for enrollment in the HCB Alternatives Waiver or within 60 days of the termination date of the last authorized waiver services;

and
• Participant has been residing in an institutional setting for greater than 30 consecutive days.

In the event of a reduction or termination of waiver services and/or enrollment, the CMA or DHCS 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.

   Continually, DHCS reviews all information submitted by the CMA or any other sources regarding participant complaints and grievances, and instances of abuse, neglect, and exploitation. Contracts between DHCS and CMAs require CMAs to implement and maintain written grievance policies and procedures describing the submission, documentation, evaluation, and resolution of all participant grievances.

   CMAs design policies and procedures that fit their unique structures and the participants they serve. Grievance policies and procedures are subject to review and approval by DHCS during QAR and as necessary. DHCS consult CMAs on handling complaints, grievances, and complicated situations. CMAs report in their quarterly utilization reports any complaints and grievances and their outcomes. Medi-Cal State Fair Hearings serve as an additional dispute resolution method for participants. A participant's right to receive a State Fair Hearing is still preserved if a participant elect to make use of the grievance process. Participants shall be informed that the employment of the additional dispute resolution mechanism does not serve as a prerequisite or substitute for a State Fair Hearing.

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:

   DHCS

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).

   CMAs must maintain and implement policies and procedures which describe the receipt/reporting, documentation, evaluation, and resolution of grievances. Grievances are categorized into verbal complaints and written complaints.

   A verbal complaint consists of any expression of dissatisfaction by a participant to the CMA in person or by

telephone. For example, a participant may verbally complain that his/her qualified case manager does not return phone calls in a timely manner. Verbal complaints are responded to verbally by the CMA and are usually resolved within 72 hours. The CMA is responsible for documenting the verbal complaint and resolution.

A written complaint is considered to be a formal complaint and consists of any written expression of dissatisfaction by a participant to the CMA. Although some CMAs design forms for participants to use when submitting written complaints, use of these forms is not obligatory. When written complaints are received, CMAs must document them in the agency's complaint log. Different levels of staff may be involved in the written complaint review process.

CMAs must provide written assurances that any participant who requests or needs assistance with the submission of a complaint shall receive it. The CMA presents and reviews these assurances with all participants in the informing at the time of enrollment and upon request. Upon completing the review of the informing notice, the CMA provides the participant a confirmation of receipt for signature.

All CMA grievance policies and procedures must be provided to the participant and/or the participant's legal representative in writing at the time of enrollment and upon request, and must address/include the following:

• A description of the process and general timelines for resolution of the complaint within the CMA. If a participant request to have DHCS contact information provided to him/her, his/her request cannot be refused by the CMA;
• Written information about the CMA grievance policies, procedures, and form(s), if applicable, must be provided to the participant at the time of enrollment and upon request, and include telephone numbers for obtaining information on State Fair Hearing appeal rights;
• All grievances must be brought to the attention of the participant's qualified case manager for first-level resolution, and must be presented at the next QAR;
• All grievances must be reviewed by the CMA or DHCS following submission of the grievance. Appropriate action is taken as a result;
• If a verbal complaint cannot be resolved by the participant's qualified case manager, the participant must be asked if he/she wishes to pursue it via a written complaint;
• If a verbal complaint becomes a written complaint, the CMA must notify DHCS of the grievance in the subsequent quarterly utilization report and provide DHCS information pertaining to the case. If the grievance is resolved, the CMA must notify DHCS of the resolution reached or outcome; and
• If a participant is unwilling to substantiate a complaint, or provide details necessary to perform an investigation, the CMA is not obligated to continue investigating the complaint and/or seek resolution, and may close the case. The CMA shall notify the participant of its decision in writing.

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 CMA or DHCS will act on and document all reported or observed critical events or issues that may affect the

health, safety and welfare of waiver participants or their service/care providers 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 or service/care providers, fraud or exploitation (including misuse of participant's funds and/or property), or a dangerous physical environment. The CMA or DHCS provides instruction to the participant, his/her legal representative/legally responsible adult(s) and/or members of his/her circle of support annually on how to report events or issues that affect or can affect the health, safety and welfare of the waiver participant.

The CMA or DHCS will use the Event/Issue Report form to document concerns or problems expressed by the participant, his/her legal representative/legally responsible adult(s), service/care providers, and/or circle of support to ensure timely investigation and resolution. If an event/issue is observed by a waiver provider it must be reported to the CMA or DHCS. The report will be documented in the participant's case record and an Event/Issue Report will be completed. 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 participant's current 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.

The Event/Issue Report form will be updated to document the resolution of the event/issue.

Incidents of possible abuse, neglect or exploitation require the CMA to report the incident immediately to the appropriate local or State agencies and to DHCS within 48 hours. The CMA and DHCS will adhere to the Health Insurance Portability and Accountably Act of 1996 to ensure the participant's Personal Health Information is protected. The CMA or DHCS 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:

• APS;
• CPS; and
• Local law enforcement.

The Event/Issue Report form is used to communicate with the CDPH, L&C on events/issues affecting participants that are related to HHAs, pediatric day health care (PDHC) providers, CLHFs, ICF/DD-CNs and CHHAs. L&C will determine if the provider is in compliance with the California Health and Safety Code Sections 1736-1736.7 (CHHA), 1760-1761.8 (PDHC), 1250(i) (CLHF) and 1250(m) (ICF/DD-CN). After the CMA consults with DHCS, DHCS forwards the completed confidential Event/Issue Report to L&C with a request that L&C investigate when there has been:

• Failure by the waiver 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 participant's current 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 current primary care physician of an incident;
• Failure to provide services or supplies as described in the POT, ordered by the participant's current 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 CMA or DHCS will continue to work with the waiver providers, the participant's current 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 CMA or DHCS 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 CMA or DHCS 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 current primary care physician and all waiver service providers receive the "HCBS Waiver Informing Notice" that includes a description of the roles and responsibilities of the participant, primary caregivers, participant's current primary care physician, and the waiver service provider(s). It also includes information on how to notify the CMA or DHCS if there are any issues or concerns that may impact the safety, health, and welfare of the participant.

The CMT evaluates the participant for issues of abuse, neglect, and exploitation during the initial face-to-face visit and at each reevaluation visit. The CMT 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 CMT documents these steps in the participant's CMR as well as any actions taken

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 CMA or DHCS, and if applicable, other agencies (CPS, APS, or law enforcement). When an event/issue is identified by, or reported to the CMA or DHCS, the CMA or DHCS 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 participant's current primary care physician was notified; and
• The name, address and phone number of the participant's current 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 CDPH, L&C. Any contact made with other agencies or individuals will be kept confidential as required by law.

The CMA will discuss the issues with DHCS and develop a plan of resolution. All plans developed to resolve identified problems are thoroughly evaluated by DHCS 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 CMA or DHCS with a waiver provider, the participant's current 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 CMA or DHCS. The CMA or DHCS will continue to follow-up with the waiver provider(s), the participant's current primary care physician, the participant, and, if appropriate, the legal representative/legally responsible adult(s), and other agencies, for resolution. The CMA or DHCS 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 CMA will discuss the issue(s) with

DHCS 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, or of the waiver provider, the waiver provider shall submit written documentation to the CMA or DHCS for review. The waiver provider and the CMA or DHCS will act immediately on any report of incidents placing the waiver participant or the provider 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. Upon learning of or observing such events, the CMA will immediately fill out an Event/Issue Report and notify DHCS within 48 hours. 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 CMA or DHCS will immediately contact the appropriate agency and provide the necessary information and documentation to assist in the investigation. The CMA will continue to follow-up with the appropriate agency, continue to update the Event/Issue Report and the participant of the situation and notify DHCS.

Events/issues referred to CDPH, L&C are tracked to ensure that the CMA or DHCS can adequately respond to the reported findings and plan for resolution of the event/issue. The CMA or DHCS 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.

California's CPS or APS program has primary responsibility to resolve reported events/incidents of abuse, neglect and/or exploitation.

In the event that CPS or APS does not take timely and appropriate action, CMAs will notify local law enforcement if the issue is observed to persist.

In the event of involvement of CPS or APS and/or local law enforcement, the CMA will continue to monitor the Waiver Participant's health and safety to ensure the issues have been resolved.

CMAs will provide documentation in the Quarterly Utilization Reports on any critical incidents that have occurred during the waiver cycle to DHCS. DHCS will review, monitor and provide technical assistance as needed to the CMAs.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints 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.** 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). 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 CMA or DHCS 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 CMT and/or via telephone contact with participants, his/her legal representative/legally responsible adult(s), waiver providers, and participant's current primary care physician. If the CMT observes or learns that restraints or seclusion are being used, an Event/Issue Report form must be completed. The CMA or DHCS must determine:

1. Whether the use of restraints is ordered by the participant's current primary care physician;
2. If a plan describing criteria for use and monitoring of restraints is documented in the participant's 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 and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

If the CMA or DHCS determines that the participant's current 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 an HHA, PDHC, CLHF or ICF/DD-CN is referred to CDPH, L&C to investigate and report on their findings. The CMA and DHCS are responsible for monitoring CDPH, L&C's investigation and findings.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

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 CMA or DHCS 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 CMT and/or via telephone contact with participants, his/her legal representative/legally responsible adult(s), waiver providers, and participant's current primary care physician. If the waiver provider, the CMA or DHCS 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 an HHA, PDHC, CLHF or ICR/DD-CN is referred to CDPH, L&C to investigate and report on their findings. The CMA and DHCS are responsible for monitoring CDPH, 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-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- (●) **The State does not permit or prohibits the use of seclusion**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

  The CMA or DHCS 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 CMT and/or via telephone contact with participants, his/her legal representative/legally responsible adult(s), waiver providers, and participant's current primary care physician. If the waiver provider, the CMA or DHCS observes or learns that seclusion is being used, an Event/Issue Report form must be completed and the appropriate law enforcement and either child or adult protective services will be contacted to report the event. Unauthorized use of seclusion by an HHA, PDHC, CLHF or ICR/DD-CN is referred to CDPH, L&C to investigate and report on their findings. The CMA and DHCS are responsible for monitoring CDPH, L&C's investigation and findings.
- ( ) **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.
  - i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
  - ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such 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 CLHF and an ICF/DD-CN residence is responsible for medication management for waiver participants unless the participant has a current primary care physician order to self-manage his/her medications.

A 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 the participant's current 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 current primary care 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.

CDPH makes at a minimum, annual visits to the CLHF and ICF/DD-CN facilities. The CMAs or DHCS 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 participant's current primary care 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 CDPH at annual provider visits.

The CMA or DHCS performs extensive client chart reviews at annual provider visits and situations of potentially harmful practices receive the appropriate follow-up. The CMA or DHCS as well as licensed nursing staff of the CLHF or ICF/DD-CN residence are trained to identify the concurrent use of contraindicated medications. If appropriate follow-up has not occurred, the CMA or DHCS provides education and training on corrective actions to handle such situations in the future. At subsequent program compliance reviews, the CMA or DHCS will follow-up regarding previous findings to ensure that necessary changes have occurred and continue to be applied, and that corrective actions are insuring participant's health and welfare. Through these reviews, the CMA or DHCS 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 an LVN or RN are required. This requirement is enforced by CDPH and DHCS.

Under the HCB Alternatives 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 CMA or DHCS works with the CLHF or 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 CMA or DHCS documents any findings of harmful and/or noncompliant practices which are found and follows up with DHCS with their plan for resolution and tracks remediation efforts to improve program performance. The CMA, DHCS, and 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:

DHCS and CDPH make, at a minimum, annual visits to the CLHF and ICF/DD-CN. During these visits, DHCS and CDPH have 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 participant's current primary care 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 CMA or DHCS. 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 the CMA, DHCS and CDPH for follow-up at least quarterly.

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 demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 HCB Alternatives Waiver cases meeting DHCS' policies and procedures indicating they are appropriately 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.

Data Source (Select one):
Program logs
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(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):
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 case records documenting the Care Management Team 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:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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.

c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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.

d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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.

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 CMA or DHCS will act on and document all reported or observed critical events or issues that may affect the health, safety and welfare of waiver participants or their service/care providers as they are discovered. Incidents of possible abuse, neglect or exploitation require the CMA to report the incident to DHCS and appropriate local or State agencies.

Following the Quality Assurance Review, DHCS will present an analysis of the findings to the CMA within 30 days. Based upon the findings and level of compliance, remediation actions will be developed and implemented by the CMA within 30 days. Effectiveness of the remediation actions will be re-evaluated at the next Quality Assurance 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 QIS 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 OIS* 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 QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

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.

DHCS performs continuous and ongoing reviews of HCB Alternatives Waiver CMA compliance standards, administration and care management activities, participant and provider records and financial statements through its required reporting process, the Quarterly Utilization Report (QUR). DHCS analyzes case records, progress notes, care management activities, assessment/reassessments, the Waiver Participant's plan of care, individual service plans, service authorization, special incidents or critical events, provider qualifications, subcontracts, financial statements or audits and any other pertinent documentation through the QPRs. The analysis of the QPRs allows DHCS to determine that documentation was done on a timely basis, with the appropriate forms and done by appropriate personnel. The specific areas of review include administrative accountability, LOC assessments, care plan, service authorization, service provision, provider qualifications, financial integrity and sustainability and Participant health and welfare.

When an individual problem is identified during the QPR process, DHCS will issue a written report of the findings and recommendations to the CMA that will include a formal written request for a CAP specific to remediating the problem. The CMA is required to respond to DHCS with a formal written plan to cover any deficiencies identified within 30 calendar days. The CAP must be specific about the actions to be taken, the personnel who will take the actions, and when the corrective action will be completed. Upon receipt of the CAP, DHCS monitors the CMAs resolution process to ensure complete remediation of the deficiency. Once the CAP is reviewed by DHCS, the CMA is given an opportunity to implement the developed strategy. Once

implementation has occurred, DHCS may conduct an on-site follow-up visit to the CMA to evaluate the effectiveness of the CMAs new practice, and/or requests submission of records for additional review by DHCS. The CMA does not receive a CAP approval letter until complete resolution has been verified by DHCS. Technical assistance is provided throughout the process on an as needed basis.

DHCS performs biennial onsite reviews to each CMA, called Quality Assurance Reviews (QARs) DHCS aggregates the results of the QARs and discovery information to develop a statewide remediation approach which includes policy dissemination through the periodic CMA meetings, the HCB Alternatives CMA Manual updates and policy letters, if needed. DHCS also provides technical assistance onsite or through on-going email and telephone contact between the CMA and DHCS. DHCS uses this aggregate data to prioritize training needs in order to schedule multi-CMA training events.

While performing the QAR should a specific CMA have significant issues, DHCS would require in writing that the CMA develop a CAP specific to correcting the issue(s). The CMA would be required to respond to DHCS with a formal written plan to cover any deficiencies identified within 30 calendar days. The CAP would be specific about the actions to be taken, the personnel who will take the actions, and the completion date of the corrective action. The plan and associated actions will be monitored by DHCS and upon successful remediation of the problem, the CAP would be approved. Technical assistance would be provided during the QAR and throughout the entire issue resolution process.

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.

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

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: Biennially

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 results of DHCS' remediation activities are analyzed in order to measure their effectiveness. This analysis results in system changes to the QURs, QARs, CMA onsite review tools, and to methods of policy dissemination, technical assistance and training.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Every eighteen months preceding the submission of the CMS372 Reports, the effectiveness of existing quality assurance systems are reviewed to determine continued efficacy. System changes are identified and implemented. The CMA QAR process, onsite review tool and the QPR are changed to reflect systemic quality improvement strategies. Quality improvement input is also solicited from the CMAs during the quarterly meetings between DHCS and CMAs.

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).

Service providers contracted under a CMA and 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 CA-MMIS Division administers the Medi-Cal claiming system and manages the State's third party fiscal intermediary (FI) contract.

Health Insurance, Portability and Accountability Act (HIPPA) compliant procedure Codes (HCPCS)are unique to each waiver service. Each CMA is only eligible to bill for the waiver services they authorize and assure have been delivered. The billing is via standardized billing forms and claims are submitted to the FI for payment. Only recognized Medi-Cal billers may be paid for waiver services.

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

DHCS Audits & Investigations (A&I) Division is responsible for ensuring the fiscal integrity and medical necessity of Medi-Cal program services, including the Home and Community Based (HCB) Alternatives Waiver. 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, or collection of overpayments. 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 claims processors and data storage providers 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 DHCS principal liaison with outside law enforcement and prosecutorial entities on Medi-Cal fraud.

WPCS claims are paid through DSS', IHSS program, CMIPSII.

DHCS examines the provider records and compares the records with the authorized services. If the received claim is correct, DHCS LTCD staff will authorize payment through CMIPS. DHCS LTCD contact A&I if claims are incorrect, to conduct a more detailed financial analysis in the event of suspicious billing practices. The state conducts routine audits, based on data mining and claim review, of all Medi-Cal billers, to ensure competency and accuracy in the paid claims.

Individual, unlicensed providers of WPCS claims are paid through DSS', IHSS program, CMIPSII, developed and managed by HP Enterprise Services. HP Enterprise Services will continue to oversee the CMIPSII system. CMIPSII validates provider claims with authorized hours and will reject any claim that exceeds the monthly authorized hours. If the received claim is correct, CMIPSII will authorize payment.

LTCD conducts routine, random claim reviews of all Medi-Cal, IHSS and WPCS billers to ensure competency and accuracy in the paid claims.

LTCD will contact A&I to conduct a more detailed financial analysis or audit in the event suspicious billing practices are identified.

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. *(For waiver actions submitted before June 1, 2014, this assurance read "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. **Sub-Assurances:**

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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 Waiver claims that were coded and paid at appropriate levels.

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** Specify:

Performance Measure:
Percent of Waiver claims paid that match the participant's POT.

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** Specify:

Performance Measure:
Percent of Waiver claims billed after the participant's date of enrollment.

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** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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.

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.
DHCS conducts ad hoc discovery activities based on a random representative sample size of all Waiver claims. DHCS will access either MIS/DSS or CMIPSII to obtain evidence that a claim submitted by a CMA was billed appropriately for the HCBS Waiver provider delivering HCB Alternatives Waiver services and was reimbursed at the established rate for the service. DHCS uses the QURs and QARs to gather data for the Financial Accountability Review which analyzes CMA and statewide trends to ensure payments are made timely to direct service providers, billed appropriately to the state, and assurance of CMAs fiscal solvency. DHCS will provide problem resolution with technical assistance and training to the CMA, when necessary.

Within 30 days of the Financial Accountability Review, DHCS will present an analysis of the findings to the CMA. Based upon the findings and level of compliance, remediation actions will be developed and implemented within 30 days by the CMA. DHCS will follow up on the effectiveness of any remedial action within 30 days. Remedial actions will be re-evaluated at the next scheduled QAR. For issues concerning fraud, LTCD refers to A&I.

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.

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).

Below is a description of the rate methodologies used to establish payment rates for HCB Alternatives Waiver services:

RATE METHODOLOGY:
DHCS Fee Schedule:
Adoption of published provider rates found in the Current California Medi-Cal Fee Schedule published at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part2/homecd_o07.doc

The services listed below (Family Training, Habilitation Services, Private Duty Nursing, and Respite) are based on the published provider rates paid to either an RN employed by an HHA or an RN that is an INP, an LVN employed by an HHA or an LVN INP, or an CHHA employed by an HHA that provides intermittent private duty nursing.

In areas where there are no CMAs, the state will continue the existing published Medi-Cal provider rates found in the current Medi-Cal Fee Schedule located at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part2/homecd_o07.doc and adoption of published provider rates applies to the care management and like services paid to either a Registered Nurse (RN) that is an Individual Nurse Provider (INP) and/or a Licensed Vocational Nurse (LVN) INP that provides case management, community transition services and/or transitional case management to Waiver Participants. Rates paid for NF/AH Waiver care management services to individual providers when CMAs are not available are published and updated, if applicable, in the Medi-Cal Provider Manual and notice of updates are sent to Medi-Cal providers by U.S. mail or by e-mail.

Continuous Nursing and Supportive Services are based on the published provider rates paid to a CLHF that were negotiated and agreed upon.

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.

HCBS SERVICE:
• 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 CDSS or DHCS.

HCBS SERVICE:
• Waiver Personal Care Services (WPCS)
• Respite (if provided by an unlicensed personal care provider)

MEDIAN RATE METHODOLOGY:
In areas where Care Management Agencies (CMAs) will be available, the State is proposing to apply the median rate to the NF/AH Waiver's care management, community transition and transitional care management services that would allow contracted CMAs to facilitate and receive fair reimbursement for administering and operationalizing the

HCB Alternatives Waiver.

This methodology requires that rates negotiated with new providers may not exceed the Department's current median rate for the same service, or the statewide current median rate, whichever is lower. This methodology is defined in California Welfare and Institutions Code section 4691.9 the Department may negotiate a rate that exceeds the median rate if necessary in order to pay employees no less than the statewide minimum wage or to provide a minimum of 24 hours or three days of paid sick leave annually.

While the law sets a cap on negotiated rates, the rate setting methodology for applicable services is one of negotiation between the Department and prospective provider. Pursuant to law the Department and provider must maintain documentation on the process to determine, and the rationale for granting any negotiated rate (e.g. cost-statements), including consideration of the type of service and any education, experience and/or professional qualifications required to provide the service.

HCBS Service:
• Case Management
• Community Transition Services
• Transitional Case Management

USUAL AND CUSTOMARY RATE METHODOLOGY:
Per California Code of Regulations (CCR), Title 17, Section 57210(19), a usual and customary rate "means the rate which is regularly charged by a vendor for a service that is used by both Medi-Cal members and/or their families and where at least 30% of the recipients of the given service are not Medi-Cal members or their families. If more than one rate is charged for a given service, the rate determined to be the usual and customary rate for a Medi-Cal member and/or family shall not exceed whichever rate is regularly charged to members of the general public who are seeking the service for an individual who is not a Medi-Cal member, and any difference between the two rates must be for extra services provided and not imposed as a surcharge to cover the cost of measures necessary for the vendor to achieve compliance with the Americans With Disabilities Act."

HCBS SERVICE:
• Environmental Accessibility Adaptations
• Personal Emergency Response (PERS) (activation and monthly service charge)
• Medical Equipment Operating Expense

Environmental Accessibility Adaptations: The CMA secures the provider that has the lowest bid.

PERS and Medical Equipment Operating Expense: The CMA secures the provider with the lowest bid. Medical Equipment Operating Expenses are payable if over $20 up to a maximum of $75.

Rates paid for HCB Alternatives 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/publications/masters-MTP/Part2/homecd_o07.doc and notices of updates are sent to Medi-Cal providers by U.S. mail or by e-mail notices.

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:

The CMA is responsible for prior authorization of all HCB Alternatives Waiver services and verifies that the requested services are in accordance with the participant's POT and are medically necessary. HCB Alternatives Waiver service providers are responsible for submitting a TAR to the CMA for prior authorization of all HCB Alternatives Waiver services except the WPCS benefit. The CMA reviews the TAR for medical necessity and to ensure services are authorized in accordance with the participant's POT. Claims for services are paid to Waiver providers and CMAs after the service is rendered.

DHCS CA-MMIS Division has overall responsibility for ensuring payment of Medi-Cal claims for provided services. CA-MMIS Division oversees the contract with the FI who is responsible for managing the CMS approved CA-MMIS.

CMAs, and HCBS Waiver providers in areas where there is no CMA, submit claims to the Medi-Cal FI 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. The FI adjudicates claims for services, resulting in one of four possible actions:

1. Paid (claim is paid);
2. Denied (claim is denied);
3. Suspended (FI 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 FI 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 CDSS, IHSS, CMIPSII.

The CMT authorizes WPCS service hours by completing a written letter of authorization, that is forwarded to the waiver participant, the WPCS provider, and DHCS who are 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 their County social services' office for review and approval. The timesheets are reconciled with the hours authorized in accordance with the waiver participant's authorized hours as identified in the POT. CMIPSII authorizes payment for claimed hours of service, documenting the hours worked, the rate of payment, and the gross amount approved for payment. CMIPSII 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:

CMAs are responsible for prior authorization of all HCB Alternatives Waiver services and verification that the requested services are in accordance with the participant's current POT and are medically necessary.

Claims for waiver services must meet either the CA-MMIS or CMIPSII 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 member and is enrolled in the HCB Alternatives Waiver;
• Satisfactory Medi-Cal eligibility status;
• Provider is an enrolled CMA or HCBS Waiver provider;
• Claim is not a duplicate;
• Claim is paid per the published rates or DHCS CMA negotiated rate;
• Participant was not institutionalized during the time covered by the claim; and
• Appropriate HCB Alternatives Waiver procedure codes.

Completed WPCS claims processed through CMIPSII 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 HCB Alternatives Waiver program;
• Provider is enrolled as a WPCS provider authorized to provide services to the HCB Alternatives Waiver participant;
• Claim is not a duplicate;
• Claim does not exceed maximum authorized hours; and
• Participant was not institutionalized for more than seven days 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:

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.**
- [x] **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:

Some CMAs are anticipated to be local county governments. They receive the same monthly case management reimbursement rates for administering the HCB Alternatives Waiver and providing case management as received by all CMAs. The rate does not exceed reasonable costs incurred in furnishing this service.

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:*

- (●) **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:

Applying to Become a CMA

The CMAs are procured through the State contracting process which involves a Request for Application (RFA).

Provider Number

After the RFA process each agency must obtain a Medi-Cal provider number through the DHCS Provider Enrollment Branch, Payment Systems Division for processing.

Disclosure / Program Integrity

Federal regulations require providers of Medicaid programs to ensure program integrity by requiring providers to disclose certain information. Medi-Cal satisfies these federal regulations for disclosure and deters fraud and abuse by requiring providers to complete DHCS 6207, the Medi-Cal Disclosure Statement form. The DHCS 6207 is submitted to the Payment Systems Division, DHCS for processing.

Provider Qualifications / Requirements

CMAs must be local governmental or private nonprofit organizations which are procured through the State contracting process which involves an RFA.

Informing New Enrollees

Once an individual is determined eligible to enroll in the HCB Alternatives Waiver, a qualified care manager describes the HCB Alternative's services, limitations, requirements and any feasible alternative programs to him/her, including the option of being institutionalized as compared to receiving HCBS through the HAB Alternatives Waiver. The qualified care manager answers any questions the interested individual/applicant may have.

Enrollment and Selections

In order to participate in the HCB Alternatives Waiver, a completed HCB Alternatives application packet must be received by DHCS which demonstrates the applicant's medically necessary needs and eligibility qualifications.

CMA Requirements

The State requires CMAs to have a formal contracting process to select qualified providers for all waiver services and to monitor the provision of services by the vendors.

Monitoring of CMA providers

DHCS performs QARs to ensure that the CMA contracting process meets DHCS' requirements, that the vendors are qualified and that the services are provided in accordance with the Waiver Participant's POT.

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.**
- ○ **This waiver is a part of a concurrent □1115/□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 □1115 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 CLHF and the ICF/DD-CN residences the waiver participant pay the facility 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 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 HCB Alternatives 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-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital, Nursing Facility, ICF/IID

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	21144.59	41527.00	62671.59	114835.00	6735.00	121570.00	58898.41
2	27207.68	33726.00	60933.68	114695.00	6735.00	121430.00	60496.32
3	32144.40	29837.00	61981.40	114600.00	6735.00	121335.00	59353.60
4	36874.02	27255.00	64129.02	114363.00	6735.00	121098.00	56968.98
5	41852.70	27278.00	69130.70	114332.00	6735.00	121067.00	51936.30

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 Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care: Hospital	Level of Care: Nursing Facility	Level of Care: ICF/IID
Year 1	8964	3496	5378	90
Year 2	8964	3496	5378	90
Year 3	8964	3496	5378	90
Year 4	8964	3496	5378	90
Year 5	8964	3496	5378	90

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:

* HCB Alternatives Waiver Enrollment experience shows that participants enrolled in the HCB Alternatives Waiver will maintain continuous enrollment for their lifetime.
* 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 reports for the HCB Alternatives Waiver and estimates for utilization of infrequently used services. The CMS 372 Reports used:

WY 1 (January 1, 2012 - December 31, 2012)
WY 2 (January 1, 2013 - December 31, 2013)
WY 3 (January 1, 2014 - December 31, 2014)

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.
• DHCS does not anticipate an additional increase in rates. The increase in costs is due to the projected increase in utilization and overtime (WPCS), cost for care management and based upon full Waiver capacity and 372 data trends from 2011-2014.
• 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 DHCS' intention to eventually have HCB Alternatives Waiver enrollment at full capacity.
• 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 end of the [previous waiver term as well as the assumption that any remaining slots will be filled during WY 1.
• Factor D cost is based on a weighted average by levels of care.

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 HCB Alternatives Waiver CMS 372 Reports for:

WY 1 (January 1, 2012 - December 31, 2012)
WY 2 (January 1, 2013 - December 31, 2013)
WY 3 (January 1, 2014 - December 31, 2014)

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 IHSS program;
• 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 each LOC were weighted into the the Factor D' estimates for current HCB Alternatives Waiver participants.
• DHCS does not anticipate an additional increase in rates. The increase in costs is due to the projected increase in utilization and overtime (IHSS) and based upon full Waiver capacity and 372 data trends from 2011-2014.
• Medicare Part D drug costs are not included in the Factor D' estimates.
• Factor D' cost is based on a weighted average by levels of care.

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 LOC for NF B, Subacute, ICF/DD-CN Non-Ventilator Dependent, ICF/DD-CN Ventilator Dependent and Acute
hospital times 365 days a year. This establishes an annual cost by level of care.

Factor G reflects the peer group for participants in this waiver. The Factor G estimates for inpatient NF B, Subacute, ICF/DD-CN Non-Ventilator Dependent, ICF/DDCN
Ventilator Dependent and Acute hospital are derived from the State's daily institutional costs for 365 consecutive days. This establishes an annual cost by level of care.

Other assumptions used for obtaining Factor G are described below.

HCB Alternatives Waiver CMS 372 reports for:

WY 1 (January 1, 2012 - December 31, 2012)
WY 2 (January 1, 2013 - December 31, 2013)
WY 3 (January 1, 2014 - December 31, 2014)

DHCS does not anticipate a mid-year rate increase. The annual increase in costs is due to the projected yearly rate increases for institutional provider types.

Factor G cost is based off a weighted average by levels of care.

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 B, Subacute, ICF/DD-CN Non-Ventilator Dependent, ICF/DD-CN Ventilator Dependent and Acute hospital stay as reported in CMS 372 reports for the HCB Alternatives Waiver. This establishes an annual cost by level of care. The CMS 372 Reports used:

WY 1 (January 1, 2012 - December 31, 2012)
WY 2 (January 1, 2013 - December 31, 2013)
WY 3 (January 1, 2014 - December 31, 2014)

DHCS does not anticipate an additional increase in rates. The annual increase in costs is due to the increase in utilization of ancillary or State Plan services.

Medicare Part D drug costs are not included in the Factor G' estimates Factor G' cost is based off a weighted average by levels of care.

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
Continuous 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:						**3443550.00**
Case Management/Coordination	Quarter Hour	4174	3.00	275.00	**3443550.00**	
Habilitation Services Total:						**61813.50**
Habilitation Services	Quarter Hour	15	406.00	10.15	**61813.50**	
Home Respite Total:						**21911.40**
Home Respite	Quarter Hour	5	658.00	6.66	**21911.40**	
Waiver Personal Care Services (WPCS) Total:						**76630860.67**
Waiver Personal Care Services Regular Time	Hour	2127	2336.87	12.83	**63771803.55**	
Waiver Personal Care Services Overtime	Hour	1786	1288.00	5.59	**12859057.12**	
Community Transition Services Total:						**28700.00**

Community Transition Services	Event	41	1.00	700.00	**28700.00**	
Continuous Nursing and Supportive Services Total:						**6451389.18**
Continuous Nursing and Supportive Services	Day	81	254.00	313.57	**6451389.18**	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						**2910600.00**
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	30	252.00	385.00	**2910600.00**	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						**1717309.44**
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	16	252.00	425.92	**1717309.44**	
Environmental Accessibility Adaptations Total:						**32520.00**
Environmental Accessibility Adaptations	Event	15	1.00	2168.00	**32520.00**	
Facility Respite Total:						**33720.00**
Facility Respite	Days	24	281.00	5.00	**33720.00**	
Family/Caregiver Training Total:						**649.60**
Family/Caregiver Training	Hours	2	8.00	40.60	**649.60**	
Medical Equipment Operating Expense Total:						**6600.00**
Medical Equipment Operating Expense	Months	24	11.00	25.00	**6600.00**	
Personal Emergency Response (PERS) Installation and Testing Total:						**35000.00**
Personal Emergency Response (PERS) Installation and Testing	Event	7	1.00	5000.00	**35000.00**	
Personal Emergency Response Systems (PERS) Total:						**2706.00**
Personal Emergency Response Systems (PERS)	Month	11	6.00	41.00	**2706.00**	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						**98072656.48**
LVN	Hours	1174	2816.00	26.92	**88997089.28**	
CHHA	Hours	141	1480.00	18.90	**3944052.00**	
RN	Hours	116	1220.00	36.26	**5131515.20**	
Transitional Case Management Total:						**90132.00**
Transitional Case Management	Hours	74	30.00	40.60	**90132.00**	
			GRAND TOTAL:			**189540118.27**

Total Estimated Unduplicated Participants:	8964
Factor D (Divide total by number of participants):	21144.59
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:						**17074200.00**
Case Management/Coordination	Quarter Hour	5174	12.00	275.00	**17074200.00**	
Habilitation Services Total:						**78297.10**
Habilitation Services	Quarter Hour	19	406.00	10.15	**78297.10**	
Home Respite Total:						**24615.15**
Home Respite	Quarter Hour	7	595.00	5.91	**24615.15**	
Waiver Personal Care Services (WPCS) Total:						**88237837.62**
Waiver Personal Care Services Regular Time	Hour	2367	2434.00	12.83	**73917196.74**	
Waiver Personal Care Services Overtime	Hour	1989	1288.00	5.59	**14320640.88**	
Community Transition Services Total:						**30294.00**
Community Transition Services	Event	51	1.00	594.00	**30294.00**	
Continuous Nursing and Supportive Services Total:						**8234348.20**
Continuous Nursing and Supportive Services	Day	101	260.00	313.57	**8234348.20**	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						**3764402.36**
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	38	257.00	385.46	**3764402.36**	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						**2079767.36**
Developmentally						

Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	19	257.00	425.92	**2079767.36**	
Environmental Accessibility Adaptations Total:						**41192.00**
Environmental Accessibility Adaptations	Event	19	1.00	2168.00	**41192.00**	
Facility Respite Total:						**42720.00**
Facility Respite	Days	24	356.00	5.00	**42720.00**	
Family/Caregiver Training Total:						**730.80**
Family/Caregiver Training	Hours	2	9.00	40.60	**730.80**	
Medical Equipment Operating Expense Total:						**8250.00**
Medical Equipment Operating Expense	Months	30	11.00	25.00	**8250.00**	
Personal Emergency Response (PERS) Installation and Testing Total:						**35000.00**
Personal Emergency Response (PERS) Installation and Testing	Event	7	1.00	5000.00	**35000.00**	
Personal Emergency Response Systems (PERS) Total:						**3444.00**
Personal Emergency Response Systems (PERS)	Months	14	6.00	41.00	**3444.00**	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						**124122480.94**
LVN	Hours	1464	2858.00	26.92	**112636295.04**	
CHHA	Hours	176	1501.00	18.90	**4992926.40**	
RN	Hours	145	1235.00	36.26	**6493259.50**	
Transitional Case Management Total:						**112056.00**
Transitional Case Management	Hour	92	30.00	40.60	**112056.00**	
				GRAND TOTAL:		**243889635.53**
				Total Estimated Unduplicated Participants:		**8964**
				Factor D (Divide total by number of participants):		**27207.68**
				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:						**20374200.00**
Case Management/Coordination	Quarter Hour	6174	12.00	275.00	**20374200.00**	
Habilitation Services Total:						**94232.60**
Habilitation Services	Quarter Hour	22	422.00	10.15	**94232.60**	
Home Respite Total:						**29644.56**
Home Respite	Quarter Hour	8	627.00	5.91	**29644.56**	
Waiver Personal Care Services (WPCS) Total:						**100826807.04**
Waiver Personal Care Services Regular Time	Hour	2624	2521.00	12.83	**84871784.32**	
Waiver Personal Care Services Overtime	Hour	2216	1288.00	5.59	**15955022.72**	
Community Transition Services Total:						**43118.46**
Community Transition Services	Event	61	1.19	594.00	**43118.46**	
Continuous Nursing and Supportive Services Total:						**9940796.14**
Continuous Nursing and Supportive Services	Day	121	262.00	313.57	**9940796.14**	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						**4480741.22**
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	45	258.32	385.46	**4480741.22**	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						**2530544.05**
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	23	258.32	425.92	**2530544.05**	
Environmental Accessibility Adaptations Total:						**49864.00**
Environmental Accessibility Adaptations	Event	23	1.00	2168.00	**49864.00**	
Facility Respite Total:						**51480.00**
Facility Respite	Days	24	429.00	5.00	**51480.00**	
Family/Caregiver Training Total:						**928.12**
Family/Caregiver Training	Hours	3	7.62	40.60	**928.12**	
Medical Equipment Operating Expense Total:						**9648.00**

Medical Equipment Operating Expense	Months	36	10.72	25.00	**9648.00**	
Personal Emergency Response (PERS) Installation and Testing Total:						**47950.00**
Personal Emergency Response (PERS) Installation and Testing	Event	7	1.37	5000.00	**47950.00**	
Personal Emergency Response Systems (PERS) Total:						**3942.56**
Personal Emergency Response Systems (PERS)	Months	16	6.01	41.00	**3942.56**	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						**149521892.91**
LVN	Hours	1754	2873.67	26.92	**135688030.49**	
CHHA	Hours	211	1507.66	18.90	**6012397.31**	
RN	Hours	173	1246.85	36.26	**7821465.11**	
Transitional Case Management Total:						**136570.28**
Transitional Case Management	Hours	110	30.58	40.60	**136570.28**	
GRAND TOTAL:						**288142359.94**
Total Estimated Unduplicated Participants:						**8964**
Factor D (Divide total by number of participants):						**32144.40**
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:						**23674200.00**
Case Management/Coordination	Quarter Hour	7174	12.00	275.00	**23674200.00**	
Habilitation Services Total:						**113263.24**
Habilitation Services	Quarter Hour	26	429.19	10.15	**113263.24**	
Home Respite Total:						**35622.41**
Home Respite	Quarter Hour	9	669.72	5.91	**35622.41**	

Waiver Personal Care Services (WPCS) Total:						**114800434.78**
Waiver Personal Care Services Regular Time	Hour	2905	2603.23	12.83	**97025375.81**	
Waiver Personal Care Services Overtime	Hour	2468	1288.41	5.59	**17775058.97**	
Community Transition Services Total:						**51874.02**
Community Transition Services	Event	71	1.23	594.00	**51874.02**	
Continuous Nursing and Supportive Services Total:						**11883669.59**
Continuous Nursing and Supportive Services	Day	141	268.78	313.57	**11883669.59**	
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services Total:						**0.00**
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	0	0.00	385.46	**0.00**	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						**0.00**
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	0	0.00	425.92	**0.00**	
Environmental Accessibility Adaptations Total:						**58536.00**
Environmental Accessibility Adaptations	Event	27	1.00	2168.00	**58536.00**	
Facility Respite Total:						**61831.20**
Facility Respite	Days	24	515.26	5.00	**61831.20**	
Family/Caregiver Training Total:						**1115.69**
Family/Caregiver Training	Hours	3	9.16	40.60	**1115.69**	
Medical Equipment Operating Expense Total:						**11592.00**
Medical Equipment Operating Expense	Months	42	11.04	25.00	**11592.00**	
Personal Emergency Response (PERS) Installation and Testing Total:						**57400.00**
Personal Emergency Response (PERS) Installation and Testing	Event	7	1.64	5000.00	**57400.00**	
Personal Emergency Response Systems (PERS) Total:						**4736.32**
Personal Emergency Response Systems (PERS)	19	19	6.08	41.00	**4736.32**	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						**179620366.00**

LVN	Hours	2044	2962.35	26.92	**163001768.33**	
CHHA	Hours	246	1553.47	18.90	**7222703.42**	
RN	Hours	202	1282.80	36.26	**9395894.26**	
Transitional Case Management Total:						**164035.37**
Transitional Case Management	Hours	129	31.32	40.60	**164035.37**	
GRAND TOTAL:						**330538676.62**
Total Estimated Unduplicated Participants:						**8964**
Factor D (Divide total by number of participants):						**36874.02**
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:						**26974200.00**
Case Management/Coordination	Quarter Hour	8174	12.00	275.00	**26974200.00**	
Habilitation Services Total:						**129144.54**
Habilitation Services	Quarter Hour	30	424.12	10.15	**129144.54**	
Home Respite Total:						**40617.66**
Home Respite	Quarter Hour	10	687.27	5.91	**40617.66**	
Waiver Personal Care Services (WPCS) Total:						**129181636.71**
Waiver Personal Care Services Regular Time	Hour	3205	2660.23	12.83	**109389056.63**	
Waiver Personal Care Services Overtime	Hour	2749	1288.00	5.59	**19792580.08**	
Community Transition Services Total:						**59180.22**
Community Transition Services	Event	81	1.23	594.00	**59180.22**	
Continuous Nursing and Supportive Services Total:						**13568791.63**
Continuous Nursing and Supportive Services	Day	161	268.77	313.57	**13568791.63**	
Developmentally Disabled/Continuous Nursing Care (DD/CNC),						**0.00**

Non-Ventilator Dependent Services Total:						
Developmentally Disabled/Continuous Nursing Care (DD/CNC), Non-Ventilator Dependent Services	Day	0	0.00	385.46	**0.00**	
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services Total:						**0.00**
Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services	Day	0	0.00	425.92	**0.00**	
Environmental Accessibility Adaptations Total:						**67208.00**
Environmental Accessibility Adaptations	Event	31	1.00	2168.00	**67208.00**	
Facility Respite Total:						**70501.20**
Facility Respite	Days	24	587.51	5.00	**70501.20**	
Family/Caregiver Training Total:						**1271.59**
Family/Caregiver Training	Hours	4	7.83	40.60	**1271.59**	
Medical Equipment Operating Expense Total:						**13224.00**
Medical Equipment Operating Expense	Months	48	11.02	25.00	**13224.00**	
Personal Emergency Response (PERS) Installation and Testing Total:						**65450.00**
Personal Emergency Response (PERS) Installation and Testing	Event	7	1.87	5000.00	**65450.00**	
Personal Emergency Response Systems (PERS) Total:						**5393.96**
Personal Emergency Response Systems (PERS)	Months	22	5.98	41.00	**5393.96**	
Private Duty Nursing - Including Home Health Aide and Shared Services Total:						**204803915.96**
LVN	Hours	2334	2958.00	26.92	**185854926.24**	
CHHA	Hours	281	1550.68	18.90	**8235506.41**	
RN	Hours	231	1279.06	36.26	**10713483.30**	
Transitional Case Management Total:						**187043.39**
Transitional Case Management	Hours	147	31.34	40.60	**187043.39**	

GRAND TOTAL:	**375167578.86**
Total Estimated Unduplicated Participants:	**8964**
Factor D (Divide total by number of participants):	**41852.70**
Average Length of Stay on the Waiver:	365