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 major changes for the In-Home Operations (IHO) Waiver renewal are:

CHANGES REQUIRED BY CMS:

HCBS Transition Plan
Language added to the Attachment #2 and Appendix C-5 to comply with the new Home and Community-Based Settings (HCBS) requirements. Since services in the IHO waiver are delivered within the participant's private home, the state therefore presumes that this dwelling meets the characteristics of home and community-based settings. Based on this assumption, the state concludes that there is no need for a transition plan.

New CMS Performance Measures
Developed new performance measures in Appendix G and Appendix H to comply with a March 12, 2014 document released by CMS titled, "Modifications to Quality Measures and Reporting in §1915(c) Home and Community Based Waivers"

Participant Satisfaction Survey
Added language to Appendix D indicating that a participant satisfaction survey shall be provided to IHO waiver participants at least once every waiver renewal.

CHANGES APPROVED IN THE 2012 NF/AH WAIVER RENEWAL ADDED TO THE IHO WAIVER:

Revised Family Training Service
Technical modification to Family Training Service to include Waiver Personal Care Services (WPCS) providers enrolled to care for the IHO participant to allow Home Health Agencies (HHAs) and Individual Nurse Practitioners (INPs) to bill for training provided to WPCS providers. Currently, HHAs and INPs were not able to bill for training WPCS providers.

Revised Habilitation Services
•Technical modification to Habilitation Services to include peer mentoring when provided by a peer with the necessary training and supervision.
•Removal of Environmental Accessibility Adaptation (EAA) and Personal Emergency Response System (PERS) service language from Non-Profit Organizations employing unlicensed providers. EAA and PERS cannot be provided by

unlicensed providers.

Removed IHSS Public Authorities
Removed IHSS Public Authorities as a waiver provider in Appendix C because there isn't a mechanism that allows them to enroll, provide and receive payment as a waiver provider, and the waiver does not utilize this provider type.

Medication Management and Administration
Appendix G-3 was corrected to include Medication Management and Administration in the IHO Waiver.

Room and Board Methodology
Added methodology for excluding the cost of room and board furnished in residential settings in Appendix I-5

OTHER CHANGES:

Removed Congregate Living Health Facilities (CLHF) as a provider from Private Duty Nursing and Facility Respite services.

ROUTINE CHANGES:

Appendix J-1 updated to included new estimates for 2015-2019

The maximum number of participants served at any point during the year in Table B-3-b was reduced due to attrition.

The Unduplicated Number of Participants in Table B-3-a were reduced due to attrition.

Appendix J-2 Derivation of Estimates updated to include new methodologies for estimating Factor G, Factor G', Factor D, and Factor D'

Appendix J-2 Derivation of Estimates updated to include new Factor D projections for Year 1, Year 2, Year 3, Year 4, and Year 5

Appendix J updated with new projections for 2015-2019

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*):
In-Home Operations 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.0457
Waiver Number:CA.0457.R02.00
Draft ID: CA.011.02.00

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

Regular Waiver

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

01/01/15

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

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

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

Nursing Facility Distinct/Part (NF D/P), NF-B Pediatric and Subacute Level-of-Care (LOC)

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for 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:

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 In-Home Operations (IHO) Waiver provides services to Medi-Cal beneficiaries who:

1) have been continuously enrolled in an IHO-administered Home and Community-Based Services (HCBS) waiver since prior to January 1, 2002, and;

2) primarily receive direct-care services rendered by a licensed nurse, or

3) have been continuously residing in an acute hospital for 36 months or greater AND their primary care physician has ordered direct-care services that are in excess of the Nursing Facility and Acute Hospital (NF/AH) Waiver for the participant's assessed level-of-care (LOC). The alternative to enrollment in this HCBS IHO Waiver is inpatient placement in a Nursing Facility – Distinct Part (NF/DP) or Nursing Facility Subacute (NF/SA).

Participants enrolled in the IHO Waiver will continue to receive medically necessary services as ordered in the participant's primary care physician-signed Plan of Treatment (POT) that was in effect on the date of the participant's enrollment in the HCBS IHO Waiver. Participants enrolled under the 36-month continuous acute hospitalization criteria are eligible to receive the type, amount and frequency of waiver and State Plan services as ordered by their primary care physician to ensure the participant's health and safety.

Waiver cost neutrality for the IHO Waiver is calculated in the aggregate, and does not exceed the cost of providing NF/DP or NF/SA inpatient facility services. Utilization of waiver and State Plan services are monitored by the use of the DHCS/IHO Menu of Health Services (MOHS). The MOHS lists all HCBS IHO Waiver services and documents the amount of services the participant has been authorized to receive.

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

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

3. Components of the Waiver Request

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

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

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect,

applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

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

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

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

- (●) **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:
On August 13, 2014, DHCS/IHO hosted an IHO Waiver Renewal webinar. The webinar provided an overview of the proposed changes to the IHO Waiver for 2015-2019. DHCS/IHO mailed an invitation letter to all active IHO Waiver beneficiaries, and the Olmstead Committee. The invitation and agenda was also posted on the IHO website.

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

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

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

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

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

Along with the public input obtained at the Olmstead meetings, the DHCS/IHO also received and utilized feedback from Independent Living Centers. Public input was also recieved during the preparation of the HCBS NF/AH Waiver, during the public comment period and at stakeholder briefings.

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:

Shen

First Name:

John

Title:

Chief, In-Home Operations Branch

Agency:

Department of Health Care Services

Address:

MS 4502, P.O. Box 997413

Address 2:

1501 Capitol Avenue

City:

Sacramento

State: **California**

Zip:

95899-7437

Phone:

(916) 440-7534 **Ext:** ☐ **TTY**

Fax:

(916) 552-9149

E-mail:

John.Shen@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: Douglas

First Name: Toby

Title: Director

Agency: Department of Health Care Services

Address: 1501 Capitol Avenue, Suite 6086

Address 2: P.O. Box 997413 MS 4000

City: Sacramento

State: **California**

Zip: 95899-7413

Phone: (916) 440-7400 **Ext:** ☐ **TTY**

Fax: (916) 440-7404

E-mail: Toby.Douglas@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:

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.

In-Home Operations Waiver Renewal Transition Plan
(January 1, 2015 through December 31, 2019)

Purpose:
In March 2014, the Centers for Medicare and Medicaid Services (CMS) implemented a requirement for states to review and evaluate current Home and Community-Based (HCB) settings, including residential and non-residential settings, and to demonstrate how California's Home and Community-Based Services (HCBS) programs comply with the new federal HCBS rules. The purpose of this Transition Plan is to ensure that individuals receiving HCBS are integrated in and have access to supports in the community, including opportunities to seek employment, work in competitive integrated settings, engage in community life, and control personal resources. Overall, this Transition Plan provides assurance that individuals receiving HCBS have the same degree of access as individuals not receiving Medi-Cal HCBS. This Transition Plan outlines the process that California's In-Home Operations (IHO) Waiver will be utilizing to ensure implementation of the new HCBS requirements.
Background:

The IHO Waiver provides services to either 1) Medi-Cal beneficiaries who have been continuously enrolled in an In Home

Operations administered waiver since prior to January 1, 2002 and require direct care services provided primarily by a licensed nurse; or 2) those who have been receiving continuous care in a hospital for 36 months or greater and have physician-ordered direct care services that are greater than those available in the Nursing Facility/Acute Hospital Waiver for the participant's assessed level of care (LOC). The current waiver was approved on January 1, 2010 and is on temporary extension through March 30, 2015 at this time.

Prior to the final rule, HCB setting requirements were based on location, geography, or physical characteristics. The final rule defines HCB Settings as more process and outcome-oriented, guided by the consumer's person-centered service plan by:
• Being integrated in and supporting full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
• Giving individuals the right to select from among various setting options, including non-disability specific settings and option for a private unit in a residential setting.
• Ensuring individuals' right of privacy, dignity and respect, and freedom from coercion and restraint.
• Optimizing autonomy and independence in making life choices, including daily activities, physical environment and with whom to interact.
• Facilitating choice regarding services and supports, and who provides them.

IHO Waiver services are delivered in the private dwellings of the Waiver Participants.
The Department of Health Care Services / In Home Operations (DHCS/IHO) therefore presumes that these dwellings meet the characteristics of home and community-based residential settings. There is no provider controlled or non-residential settings in the IHO Waiver.

Summary:
The DHCS/IHO has identified and reviewed the IHO Waiver provider types and services pursuant to ensuring they meet the new Federal HCB settings requirements.

The below listed provider types provide IHO Waiver services and benefits to the IHO Waiver Participant within the participant's private home. As of October 2014, there are currently 125 Waiver Participants enrolled in the IHO Waiver.
The IHO Waiver provider types include all of the following:
• Durable Medical Equipment Provider
• Employment Agency
• Home Health Agency
• Licensed Clinical Social Worker
• Licensed Psychologist
• Licensed Vocational Nurse
• Marriage Family Therapist
• Personal Care Agency
• Private Nonprofit or Proprietary Agency
• Professional Corporation
• Registered Nurse
• Waiver Personal Care Services Provider
The purpose of the IHO Waiver is to enable participants to remain in the least restrictive home-based setting. All IHO Waiver services focus on enabling the participant to remain in the community. Waiver Participants have the freedom of choice to participate in the IHO Waiver; they may elect to accept or refuse any service. Services are authorized upon physician order and as directed in the person-centered care plan.
The IHO Waiver Participants will not be excluded from the Statewide Transition Plan survey and assessment process. The Statewide Transition Plan process entails:
1. Development of participant self-surveys
2. Development of provider self-surveys
3. Distribution of self-surveys
4. Review of self-surveys
5. On-site assessments, if triggered
6. Review of on-site assessments to determine how each setting meets or does not meet the federal HCB setting requirements
7. Remedial action and steps to come into compliance
8. Ongoing Appeals, Disputes and Complaints process
9. Continuing and ongoing monitoring for compliance

Monitoring Process:
DHCS/IHO will monitor Waiver Participants' private dwellings for ongoing compliance through the annual audit and face to face assessment, which are core components to the IHO quality assurance plan. HCB setting assessment questions will be added to the IHO compliance audit to ensure ongoing compliance. The self-assessments, on-site evaluations and/or other data collection methods will be used to identify continued compliance with the federal regulations.
Reference Material:

Link to DHCS Statewide Transition Plan:
http://www.dhcs.ca.gov/services/ltc/Pages/HCBSStatewideTransitionPlan.aspx

http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-10-14.pdf

The Federal Regulatory requirement can be found at 42 CFR Section 441.301(c)(4)(5) and Section 441.710(a)(1)(2).
Attachment B

http://www.ecfr.gov/cgi-bin/text-idx?SID=3fa141f9fc903bdf5a2cb2997b8d14c6&node=se42.4.441_1301&rgn=div8

http://www.ecfr.gov/cgi-bin/text-idx?SID=3fa141f9fc903bdf5a2cb2997b8d14c6&node=se42.4.441_1710&rgn=div8

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Per request in the CMS Final Report (control #0457) dated December 27, 2013, a satisfaction survey will be sent to all IHO Participants in 2019.

Appendix A: Waiver Administration and Operation

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

   (●) **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   (●) **The Medical Assistance Unit.**

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

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

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

   (Complete item A-2-a).

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

   Specify the division/unit name:

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The

interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

   ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

   ◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

   ◉ **Not applicable**

   ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

   ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

   Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.
Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency
Participant waiver enrollment	☑
Waiver enrollment managed against approved limits	☑
Waiver expenditures managed against approved levels	☑
Level of care evaluation	☑
Review of Participant service plans	☑
Prior authorization of waiver services	☑
Utilization management	☑
Qualified provider enrollment	☑
Execution of Medicaid provider agreements	☑

Function	Medicaid Agency
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.

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

The QAU utilizes the following tools for discovery:

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

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 CMIS is a database developed and implemented in 2005. DHCS/IHO uses information from CMIS to establish quality indicators that will help determine if changes need to be made to the waiver enrollment criteria, services, providers, or any other aspect of waiver administration. CMIS can provide data on how potential participants are referred to the waiver, how many referrals are received, and documents the timeliness of the referral, evaluation, and enrollment process. CMIS also captures data on applicants who are placed on the waitlist, and tracks the reasons active waiver cases are closed. CMIS also allows DHCS/IHO to document the utilization and cost of WPCS, as well as track Notice of Actions (NOAs) and captures the number of requests for State Fair Hearings along with the outcomes of those Fair Hearings.

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

• Evidence of the accuracy of LOC evaluation;

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

• Evidence the POT addresses all of the participant's identified needs' and to assure the participant's health and welfare;

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

• Evidence the POT reflects all the participant's services are planned and implemented in accordance with their unique needs, expressed preferences and decisions, personal goals, abilities, and 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)(s) and/or circle of support to make selections among service options and providers;

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

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

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

The annual Case Record Review also uses the Record Review Tool to document compliance with the assurances provided in the HCBS IHO Waiver and DHCS/IHO' policies and procedures for the Provider Visit Review conducted annually by DHCS/IHO NEs. The Provider Visit Review is conducted on a sample of the waiver providers who have provided services during the designated waiver year. The Provider Visit Overdue Report is used to track annual provider visits that are 30 days overdue. The Provider Visit Review is used to discover if the DHCS/IHO staff has conducted timely provider visits, ensures providers meet the waiver licensing and certification requirements, provides written feedback to the provider following a provider visit, notifies appropriate agencies of provider issues that effect the health and safety of the waiver participant, and documents that the provider has received HCBS waiver training.

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

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

Using these tools, DHCS/IHO will be able to collect and analyze data for trends and patterns of populations served document compliance with assurance provided in the IHO Waiver. DHCS/IHO can then develop any needed remedial actions deemed necessary to provide the best service to the HCBS waiver population while assuring compliance with waiver assurances as well as DHCS/IHO polices 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:

Participants served under the HCBS IHO Waiver will need to have an identified support network system available to them in the event the provider of direct care services is not able to provide the total number of hours approved and authorized by DHCS/IHO. The support network system may consist of care providers, community-based organizations, family members, primary care physicians, home health agencies, members of the participant's medical team, licensed foster parent(s) or any other individual that is part of the participant's circle of support.

The participant's circle of support may consist of family members, care givers, legal representative/legally responsible adult, and any other individual named by the participant. Members of the support network providing direct care services in the absence of the authorized waiver provider will be identified on the Plan of Treatment (POT). The POT must be signed by the participant's primary care physician. For purposes of the HCBS IHO Waiver, the primary care physician is the physician that oversees the participant's home program.

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

1. NF DP services pursuant to W&I Code §21409.21(c)(1), and California Code of Regulations(CCR), Title 22, CCR, § 51124 and § 51335;

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

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

4. NF Pediatric Subacute services, pursuant to Title 22, CCR, § 51124.6.

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

NF LOC waiver participants must also:

-Meet the criteria for care in a nursing facility for at least 365 consecutive days; or

-Be receiving continuous services in an acute hospital for 36-months or more, and have primary care physician ordered direct care services that are in excess of the NF/Acute Hospital (NF/AH) Waiver for the participant's LOC. All primary care physician-ordered services must be in place at the time of discharge from the acute hospital to ensure the participant's health and safety.

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:

    Individuals eligible for the IHO waiver have an established home care program described in their individual Plan of Treatment (POT). Their level of expenditure for the waiver and State plan services as described on their POT at the time of their enrollment is established as their individual cost limit.
- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

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

○ **The following dollar amount:**

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)

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

The DHCS/IHO NE utilizes the following procedures for waiver participants at the time of enrollment.

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

2. Upon determination of the participant's LOC and the need for the services, the DHCS/IHO NE provides information to the participant and/or his/her legal representative/legally responsible adult(s), and/or circle of support on the requirement that the participant's institutional cost limit is based upon the cost of his/her authorized waiver and State plan services that are described on the participant's initial POT at the time of the participant's enrollment in the HCBS IHO Waiver or, for participant's who meet the 36-month continuous care in an acute hospital criteria, their institutional cost limit is based upon the cost of their primary care physician ordered direct care services that

meet the participant's current needs to remain safely in the home at the time of the assessment visit.

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

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

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

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

- [x] **Other safeguard(s)**

Specify:

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

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

2. The participant is reevaluated to determine if he/she meets the criteria for another LOC and/or facility type in this waiver. Upon determination of a change in the LOC and facility type, the appropriate institutional cost limit will be used in the MOHS to determine if the cost of the participant's services to ensure his/her health and safety meet the waiver's cost neutrality requirement.

3. If the cost of the participant's services exceed his/her cost limit and the participant does not meet the criteria for another LOC and facility type within this waiver, the DHCS/IHO NE will contact the participant and/or his/her legal representative/legally responsible adult, the participant's HCBS IHO Waiver Case Manager/Coordinator, and the participant's primary care physician to discuss alternative options, which may include transfer to another California HCBS Waiver, providing additional State plan services (if available and/or appropriate) or admission into a facility.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	125
Year 2	120
Year 3	115
Year 4	110
Year 5	106

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	125
Year 2	120
Year 3	115
Year 4	110
Year 5	106

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).**

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 HCBS IHO Waiver will not exceeded the capacity described in Appendix B-3(a). Enrollment is based upon a first come first serve basis.

An individual requesting HCBS IHO Waiver services must complete and submit a HCBS Waiver Application to IHO. The DHCS/IHO NE will identify the applicant's need for the HCBS IHO Waiver based on the information provided and schedule a face-to-face meeting to assess the individual for enrollment and provide the participant and/or legal representative/legally responsible adult with information on the HCBS IHO Waiver. Enrollment into the HCBS IHO Waiver is limited to the maximum number of waiver slots authorized for each waiver year.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**
2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (●) **No**
   - ( ) **Yes**

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

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional State supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

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

Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

All other mandatory and optional eligibility groups undert the Medi-Cal State Plan are included.

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

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

Select one and complete Appendix B-5.

- (●) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- ( ) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

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

Select one:

- ( ) **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

○ **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount: [ ]

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 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 amounts 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 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 (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-5-a 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 that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

   i. **Minimum number of services.**

   The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

   - (●) **The provision of waiver services at least monthly**
   - ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

   If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

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

- (●) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**

○ **By an entity under contract with the Medicaid agency.**

Specify the entity:

○ **Other**
Specify:

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

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

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

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

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

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

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

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

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

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

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

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

- ○ **Every three months**
- ○ **Every six months**
- ○ **Every twelve months**
- ◉ **Other schedule**

Specify the other schedule:

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

Level I participants are reevaluated at least once every 365 days. Participants assessed at Level I are medically stable, have not recently been hospitalized for emergent care, and have no eligibility or staffing issues.

Level 2 participants are reevaluated more often, between 270 and 365 days.
Participants assessed at Level 2 have minor staffing or durable medical equipment issues and maintains regular contact with the DHCS/IHO NE.

Level 3 participants are reevaluated more often, between 180 days and 270 days. Participants assessed at Level 3 have high turnover of waiver providers, have had four or more unscheduled hospitalizations in the previous 12 month period, and/or had difficulty in obtaining primary care physician ordered medically-necessary services.

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

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

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

○ **The qualifications are different.**
Specify the qualifications:

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

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

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The LOC evaluation records and reevaluations are maintained in a participant's case record or in electronically retrievable participant files with the assigned DHCS/IHO NE.

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 IHO 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):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data		**Sampling Approach** *(check each that applies):*

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

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

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.

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 IHO Waiver participant's LOC determinations and redeterminations that are completed accurately based on waiver criteria as found in Title 22 and supported by appropriate medical documentation.

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Percent of IHO Waiver participants with LOC assessment confirmed by NE Supervisor for accuracy.

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**

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

Performance Measure:
Percent of IHO Waiver participant's LOC determinations that were assessed by an IHO NE II.

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**

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

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

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

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

The DHCS/IHO NE is responsible for the evaluation visit and waiver eligibility determination. The DHCS/IHO staff consists of registered nurses (RN), identified as DHCS/IHO NEs and their Supervisor who is also a RN. The DHCS/IHO NE must submit evidence of the evaluation visit and documentation of the LOC determination to the DHCS/IHO Supervisor for the applicant to be enrolled in the HCBS IHO Waiver. Only the DHCS/IHO Supervisor and the QAU has permissions to enter the enrollment information in CMIS. The CMIS has an edit that will not allow the participant to be opened to the waiver unless the date of the evaluation visit has been entered. Opening the waiver is documented by entering the date the participant was approved eligible for the CMS approved HCBS IHO Waiver.

Re-evaluations of LOC determinations are conducted as described in Appendix B. The DHCS/IHO NE is responsible for conducting timely LOC re-evaluations. QAU uses CMIS to discover the timeliness of the reevaluation LOC determinations using the Home Visit Over Due Report. This report calculates the date of the next LOC re-evaluation based upon the date of the last LOC evaluation and the participant's level of case management.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The QAU will run quarterly reports identifying the home visit date, enrollment date and LOC determinations for all cases opened for that quarter. An annual report and analyses will be provided to the DHCS/IHO Section Chief, Managers and Supervisors, here after referred to, as DHCS/IHO Management Team. Based upon the report, remediation actions will be developed by the DHCS/IHO Management Team and QAU. The QAU and Supervisors will provide training to the DHCS/IHO NEs on the remediation activities. The QAU

will conduct monthly follow-up discovery activities to determine the effectiveness of the remediation actions and ensure understandability and user-friendly assistance is available.

The QAU runs a quarterly report that identifies participants who have not had their LOC re-evaluation completed within 30 days of the calculated date. These reports are provided to the DHCS/IHO Management Team for the development of remediation activities to ensure regular, systematic, and objective methods are used to monitor a participant's well being and health status. The QAU provides an annual report and analysis of the timeliness of the re-evaluation visits to the DHCS/IHO Management Team. Remediation actions will be developed based upon the level of compliance. The QAU and Supervisors will provide training to DHCS/IHO NE. The QAU will conduct monthly follow-up discovery activities to determine the effectiveness of the remediation actions.
The QAU and DHCS/IHO Medical Consultant conduct the annual Case Record Review on a sample of participants who were enrolled in the waiver during the reporting waiver year. The QAU uses the Sample Size Calculator as previously described to determine the number cases for review. The cases selected for review will reflect the percentage of cases for each LOC in the waiver, percentage of cases per DHCS/IHO field office and ensure cases from all DHCS/IHO NEs are represented. The DHCS/IHO NE use a case report form to document their observations, actions, and information obtained during the participant's initial and re-evaluation visit. The DHCS/IHO NE document the participant's medical care needs and the justification of the LOC determination in the case report and use the criteria and regulations cited in the waiver in making the LOC determinations. It is DHCS/IHO' policy that the Supervisor reviews all case reports. Once the Supervisor has determined the case report is complete and is in agreement with the LOC determination, the Supervisor signs and dates the case report. If the Supervisor and DHCS/IHO NE are not in agreement with the LOC determination, the case report is reviewed by the DHCS/IHO Medical Consultant. The DHCS/IHO Medical Consultant's LOC determination is final and documented in the case report.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

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

The following is representative of the DHCS:

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

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

Appendix C: Participant Services

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

a. **Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	Case Management/Coordination		
Statutory Service	Habilitation Services		
Statutory Service	Home Respite		
Statutory Service	Waiver Personal Care Services (WPCS) and Personal Care Services		
Other Service	Community Transition 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 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):*
Case management/Coordination services are designed to assess the participant and determine their need for medical, psycho-social, social and other services, and to assist them in gaining access to those needed services, regardless of the funding source, to ensure the participant's health and safety and support of his/her home and community-based program. Case managers/coordinators also assist in acquiring personal care providers as described in the participant's plan of care. Case managers/coordinators work with the participant, his/her legal representative/legally responsible adult and/or circle of support, and primary care physician in developing goals and identifying a course of action to respond to the assessed needs of the participant, and in the development and updating of the participant's primary care physician-signed POT. Case managers/coordinators assist the participant in understanding the various services he/she is receiving or may receive and the impact, if any, of the services received/requested, based on the source of funding, as well as oversee the implementation of the services described in the POT, and evaluate the effectiveness of those services. Case management/coordination responsibilities include assessing, care planning, locating, coordinating, and monitoring services for community-based participants on the waiver. Case management/service coordination services do not include the direct delivery of any service. HCBS RN providers providing case management/coordination services also supervise, monitor, and train HCBS LVN providers of private duty nursing services. Waiver participants may select case management services for monitoring and training his/her Waiver Personal Care Service (WPCS) providers. A WPCS provider is an individual employed directly by the waiver participant receiving WPCS services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
None

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

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

Provider Category	Provider Type Title
Individual	HCBS Benefit Provider - Licensed Psychologist

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
HCBS Waiver Nurse Provider - Registered Nurse (RN)
Provider Qualifications
License *(specify):*
HCBS Registered Nurse (RN)
BPC §§2725 et seq.
Title 22, §51067;
Title 16, §§1409-1419.4
Certificate *(specify):*
N/A
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

Under the HCBS IHO Waiver, the role of the HCBS Waiver Nurse Provider – Registered Nurse (RN) is to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Adaptations (EAA)
• Family Training
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Private Duty Nursing (PDN)
• Respite Care
• Transitional Case Management (TCM) 1.

Definitions:
a. "HCBS Waiver Nurse Provider – Registered Nurse (RN) " means a RN, who provides HCBS Waiver RN services, as defined in subsection A.2, below, and, in this capacity, is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

A HCBS Waiver RN may be a parent, stepparent, foster parent of a minor, a spouse, or legal guardian of the individual only under the following circumstances: there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained by only using this individual. DHCS/IHO may require additional documentation to support requests of this nature. Documentation required before DHCS/IHO can authorize such request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as a posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not hired or refused employment, if offered.

b. "HCBS Waiver RN services" means private duty nursing services, as described the in HCBS IHO Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an HCBS Waiver RN, as defined in subsection A.1, above, within his/her

scope of practice. Such services shall not include nursing services provided in a licensed health facility.

c. “Private duty nursing services” means services provided by a RN, which are more individual and continuous than those routinely available through a home health agency as in part-time or intermittent care on a limited basis.

d. “Medi-Cal Consultant” means either a RN or Physician, who is licensed to practice in the State and is an employee of DHCS/IHO.

e. “Education and/or training requirements” means any type of formal instruction related to the care needs of the individual for whom services are being requested. Examples of this could include certifications in a particular field, appropriate to the licensure status of the nurse; or continuing education units in the needs of the waiver participant, such as wound or pain management.

f. “Evaluation of theoretical knowledge and manual skills” means an assessment conducted by the RN of the licensed vocational nurse (LVN) in which the LVN is able to demonstrate competency in the provision of skilled nursing services. Examples of this could include having the LVN verbalize requirements for a certain procedure or process; having the RN review a certain task, demonstrate the task and then observing the LVN perform the tasks as prescribed on the POT. This evaluation would need to be documented and provided to DHCS/IHO as indicated.
Requirements of the HCBS Waiver RN:

1. Registered Nurse (RN) acting as the direct care provider:

a. The initial Treatment Authorization Request (TAR) shall be accompanied by all of the following documentation:
i. Current license to practice as a RN in the State of California.
ii. Current Basic Life Support (BLS) certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, which shall include at least one of the following:

A. A minimum of 1000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.

B. A minimum of 2000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT.

C. A minimum of 2000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) specified on the TAR and POT.

D. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS/IHO, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specified on the TAR and POT.

iv. A detailed POT that reflects an appropriate nursing assessment of the waiver participant, interventions, and the primary care physician’s orders.

A. The appropriateness of the nursing assessment and interventions shall be determined by the Medi-Cal consultant based upon the waiver participant’s medical condition and care need(s).

B. The POT shall be signed by the waiver participant, the RN, and the waiver participant’s primary care physician, and shall contain the dates of service.

v. Signed release form from the waiver participant’s primary care physician, which shall specify both of the following:
A. The primary care physician has knowledge that the RN providing care to the waiver participant is

doing so without the affiliation of a home health agency or other licensed health care agency of record.

B. The primary care physician is willing to accept responsibility for the care rendered to the waiver participant.

vi. Written home safety evaluation, in a format acceptable to DHCS/IHO that demonstrates that the waiver participant's home environment supports the health and safety of the individual. This documentation shall include all of the following:

A. The area where the waiver participant will be cared for will accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies necessary to maintain the individual in the home in comfort and safety, and to facilitate the nursing care required.

B. Primary and back-up utility, communication, and fire safety systems and devices are installed and available in working order, which shall include grounded electrical outlets, smoke detectors, fire extinguisher, telephone, and notification of utility, emergency, and rescue systems that a person with special needs resides in the home.

C. The home complies with local fire, safety, building, and zoning ordinances, and the number of persons residing in the home does not exceed that permitted by such ordinances.

D. All medical equipment, supplies, primary and back-up systems, and other services and supports, identified in the POT, are in place and available in working order, or have been ordered and will be in place at the time the waiver participant is placed in the home.

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

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:
i. Evidence of renewal of BLS certification and RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/IHO, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.
iii. Written evidence, in a format acceptable to DHCS/IHO, of on-going contact with the waiver participant's primary care physician for the purpose of informing the primary care physician of the individual's progress, updating, or revising of the POT, and renewal of physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated primary care physician orders. The updated POT shall be signed by the waiver participant's primary care physician, the RN, the waiver participant and will contain the dates of service.

2. RN case manager, waiver service coordinator, transitional case manager, and/or supervisor acting as the supervisor for a HCBS Waiver LVN:

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current license to practice as an RN in the State of California.
ii. Current BLS certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience providing case management, service coordination, and/or supervision or delegating nursing care tasks to an LVN or other subordinate staff.
iv. Written summary, in a format acceptable to DHCS/IHO, of nursing care tasks that have been delegated to the LVN.

b. All subsequent reauthorization TARs shall be accompanied by all of the following

documentation, as specified:

i. Evidence of renewal of BLS certification and RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/IHO, of all case management, service coordination and/or supervisory activities which shall include all of the following:

A. Evaluation of the LVN's theoretical knowledge and manual skills needed to care for the individual for whom services have been requested.

B. The training provided to the LVN, as needed, to ensure appropriate care to the waiver participant for whom services have been requested.

C. Monitoring of the care rendered by the LVN, which shall include validation of post-training performance.

D. Any change in the nursing care tasks delegated to the LVN.

E. Evaluation of the case management and/or waiver coordination activities provided.
iii. Written evidence of ongoing contact with the waiver participant's primary care physician, as specified in section B., subsection 1(b)(iii), "requirements of the HCBS Waiver RN," above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the HCBS Waiver RN," above.

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Non-Profit Agency
Provider Qualifications

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

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

A Non-Profit Organization is a California service entity organized and operated under the United States Internal Revenue Code Section 501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBS IHO Waiver SOP and Medi-Cal Provider requirements may provide HCBS IHO Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified supervised unlicensed staff.

A Non-Profit Organization may provide the following HCBS IHO Waiver services:
• Case Management/Coordination (CM/C)
• Community Transition Services (CTS)
• Environmental Accessibility Adaptations (EEA)

• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response Systems (PERS)
• Transitional Case Management (TCM)
• Home Respite
• Waiver Personal Care Services (WPCS)

Minimum qualifications for a Non-Profit Organization functioning as an HCBS IHO Waiver Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program possesses a Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community, or have al least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. The Non-Profit Organization shall maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. The Non-Profit Organization is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. The Non-Profit Organization is responsible for providing training and/or in-services to staff eligible to provide HCBS IHO Waiver services and at least annually reviews the HCBS IHO Waiver services requirements. Training of HCBS IHO Waiver service providers must be specific to the conditions and care of HCBS IHO Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBS IHO Waiver.

8. The Non-Profit Organization is responsible for the maintenance of waiver participant case documentation and financial records which support the claims for waiver services for a minimum period of three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), License Psychologist and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within his/her scope of licensure in the State of California. The Non-Profit Organization must maintain records of licensing for inspection and review by DHCS/IHO. The Non-Profit Organization must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM, TCM, CTS, HS, EAA, PERS, and/or MEOE to the elderly and/or persons with disabilities living in the community.

The Non-Profit Organization must maintain records and documentation of any and all requirements of the waiver/SOP for inspection and review by DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/IHO

within 30 days of the change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS/IHO.

10. Employs qualified professional providers to provide HCBS IHO CM/C, CTS, HS, EAA, PERS, TCM, and/or MEOE services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Must have earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM and/or MEOE services to the elderly and/or persons with disabilities living in the community.
The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation Services, which may include activities commonly described as peer mentoring, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher with 1000 hours experience in providing supervision to providers of services to the elderly and/or persons with disabilities living in the community, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have at least 1000 hours work experience in providing services to the elderly and/or persons with disabilities living in the community, or:

b. Have two years of experience in providing services to the elderly and/or persons with disabilities living in the community, through an organization or agency, or

c. Have one year experience as a Peer Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or in the community, through and organization or agency.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS/IHO.

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

a. Develop the IHO Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest, the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interests and medical care needs are addressed. The POT will identify all the choice and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and

b. Facilitate the process of collaboration and assessment with the participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician and/or the case manager/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and care needs of the participant. Assist the participant in accessing services that

are beyond the licensed professional's scope of practice, credentialing, or experience. The POT must be updated and signed by the participant and the primary care physician no less frequently than once every six months.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's Registry of Charitable Trusts

Frequency of Verification:

Annually

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - Licensed Clinical Social Worker (LCSW)

Provider Qualifications

License *(specify):*

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

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

A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the HCBS IHO Waiver, the role of a LCSW as a HCBS IHO Waiver Service Provider is to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Accessibility Adaptations (EAA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Transitional Case Management (TCM)

A LCSW who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a LCSW in the State of California.

2. Have work experience that includes, at least, a minimum of 1000 hours of providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The Licensed Clinical Social Worker must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management or transitional case management services within the scope of practice of a LCSW consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO, as follows:

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

b. Facilitate the process of assessing the beneficiary at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the beneficiary's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the beneficiary, as determined by the primary care physician. Assist the beneficiary in accessing medical care services that are beyond the LCSW's scope of practice. The POT is updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

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

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

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

Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a MFT. Under the HCBS Waiver, the role of a MFT as a HCBS IHO Waiver Service Provider is to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Accessibility Adaptations (EAA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Transitional Case Management (TCM)

A MFT who functions as a HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a MFT in the State of California.

2. Have work experience that includes, at least a minimum of 1000 hours experience in providing case management services to the elderly and/or persons with disabilities living in the community.

3. The MFT must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management/coordination services consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO and within the MFT's scope of practice as follows:

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

b. Within the MFT's scope of practice, facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the MFT's scope of practice. The POT is updated and signed by the primary care physician no less frequently than once every six months
CBS Waiver Standards of Participation
Verification of Provider Qualifications
Entity Responsible for Verification:

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

Appendix C: Participant Services

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

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

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

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

A Professional Corporation is a provider that employs individuals who provide services authorized under the HCBS IHO Waiver and is enrolled as an HCBS IHO Waiver Professional Corporation provider in the HCBS IHO Waiver, and meets and maintains the SOP minimal qualifications for a Professional Corporation. Under the HCBS IHO Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Accessibility Adaptations (EAA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Transitional Case Management (TCM)

1. The following are the licensed persons permitted to provide the above listed services as Professional Corporations to waiver participants under the terms of the HCBS IHO Waiver:

a. Licensed Psychologists (See Business and Professions Code section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;

b. Licensed Clinical Social Workers (LCSW) (See Business and Professions Code section 4996, et seq.); operating a Professional Corporation pursuant to Corporations Code section 13400, et seq., and

c. Marriage and Family Therapists (MFT) (See Business and Professions Code section 4980, et seq.) operating as a Professional Corporation pursuant to Corporations Code section 13400, et seq.

2. A Professional Corporation who functions as a HCBS IHO Waiver Service Provider shall:

a. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to Corporations Code section 13400, et seq., or if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation. Good standing of a domestic or foreign professional corporation must be maintained as long as the professional corporation is enrolled as an HCBS IHO Waiver provider. All Professional Corporations enrolling

as HCBS IHO Waiver providers must provide a Certificate of Status of good standing to do business in the State of California (available from the Secretary of State's Office) upon enrollment and provide a current certificate of registration (pursuant to Corporations Code section 13401(b)) provided by the governmental agency regulating the profession. Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the certificate of registration. (Corporations Code section 13401(b)).

b. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.

c. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

i. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by DHCS/IHO. The professional corporation must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

ii. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 hours of experience in providing case management services to the elderly and/or persons with disabilities living in the community.

The Professional Corporation must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS/IHO.

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

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

ii. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the licensed person's scope of practice. The POT must be updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - Licensed Psychologist

Provider Qualifications

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

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

A Licensed Psychologist is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a Licensed Psychologist. Under the HCBS IHO Waiver, the role of a Licensed Psychologist as a HCBS IHO Waiver Service Provider is to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Accessibility Adaptations (EAA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Transitional Case Management (TCM)

A Licensed Psychologist who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California.

2. Have work experience that includes, at least a minimum of 1000 hours of experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The Licensed Psychologist must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management services within the scope of practice of a Licensed Psychologist consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO as follows:

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

b. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice. The POT must be updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Habilitation Services

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 a peer with the necessary training and supervision. Habilitation services include training on the use of public transportation; personal skills development in conflict resolution; community participation; developing and maintaining interpersonal relationships; personal habits; daily living skills (cooking, cleaning, shopping, money management) and community resource awareness such as police, fire, or local services to support independence in the community.

It also includes assistance with: locating, using and caring for canine and other animal companions specifically trained to provide assistance; selecting and moving into a home; locating and choosing suitable housemates; locating household furnishings; settling disputes with landlords; managing personal financial affairs; recruiting, screening, hiring, training, supervising, and dismissing personal attendants; dealing with and responding appropriately to governmental agencies and personnel; asserting civil and statutory rights through self-advocacy, and building and maintaining interpersonal relationships, including a circle of support.

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

None

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation Services

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

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

Under the HCBS IHO Waiver, the role of the HCBS Waiver Nurse Provider – Registered Nurse (RN) is to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Adaptations (EAA)
• Family Training
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Private Duty Nursing (PDN)
• Respite Care
• Transitional Case Management (TCM) 1.

Definitions:
a. “HCBS Waiver Nurse Provider – Registered Nurse (RN) ” means a RN, who provides HCBS

Waiver RN services, as defined in subsection A.2, below, and, in this capacity, is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

A HCBS Waiver RN may be a parent, stepparent, foster parent of a minor, a spouse, or legal guardian of the individual only under the following circumstances: there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained by only using this individual. DHCS/IHO may require additional documentation to support requests of this nature. Documentation required before DHCS/IHO can authorize such request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as a posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not hired or refused employment, if offered.

b. “HCBS Waiver RN services” means private duty nursing services, as described the in HCBS IHO Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an HCBS Waiver RN, as defined in subsection A.1, above, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

c. “Private duty nursing services” means services provided by a RN, which are more individual and continuous than those routinely available through a home health agency as in part-time or intermittent care on a limited basis.

d. “Medi-Cal Consultant” means either a RN or Physician, who is licensed to practice in the State and is an employee of DHCS/IHO.

e. “Education and/or training requirements” means any type of formal instruction related to the care needs of the individual for whom services are being requested. Examples of this could include certifications in a particular field, appropriate to the licensure status of the nurse; or continuing education units in the needs of the waiver participant, such as wound or pain management.

f. “Evaluation of theoretical knowledge and manual skills” means an assessment conducted by the RN of the licensed vocational nurse (LVN) in which the LVN is able to demonstrate competency in the provision of skilled nursing services. Examples of this could include having the LVN verbalize requirements for a certain procedure or process; having the RN review a certain task, demonstrate the task and then observing the LVN perform the tasks as prescribed on the POT. This evaluation would need to be documented and provided to DHCS/IHO as indicated.
Requirements of the HCBS Waiver RN:
1. Registered Nurse (RN) acting as the direct care provider:
a. The initial Treatment Authorization Request (TAR) shall be accompanied by all of the following documentation:
i. Current license to practice as a RN in the State of California.
ii. Current Basic Life Support (BLS) certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, which shall include at least one of the following:

A. A minimum of 1000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.

B. A minimum of 2000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT.

C. A minimum of 2000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) specified on the TAR and POT.

D. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS/IHO, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specified on the TAR and POT.

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

A. The appropriateness of the nursing assessment and interventions shall be determined by the Medi-Cal consultant based upon the waiver participant's medical condition and care need(s).

B. The POT shall be signed by the waiver participant, the RN, and the waiver participant's primary care physician, and shall contain the dates of service.

v. Signed release form from the waiver participant's primary care physician, which shall specify both of the following:
A. The primary care physician has knowledge that the RN providing care to the waiver participant is doing so without the affiliation of a home health agency or other licensed health care agency of record.

B. The primary care physician is willing to accept responsibility for the care rendered to the waiver participant.

vi. Written home safety evaluation, in a format acceptable to DHCS/IHO that demonstrates that the waiver participant's home environment supports the health and safety of the individual. This documentation shall include all of the following:
A. The area where the waiver participant will be cared for will accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies necessary to maintain the individual in the home in comfort and safety, and to facilitate the nursing care required.

B. Primary and back-up utility, communication, and fire safety systems and devices are installed and available in working order, which shall include grounded electrical outlets, smoke detectors, fire extinguisher, telephone, and notification of utility, emergency, and rescue systems that a person with special needs resides in the home.

C. The home complies with local fire, safety, building, and zoning ordinances, and the number of persons residing in the home does not exceed that permitted by such ordinances.

D. All medical equipment, supplies, primary and back-up systems, and other services and supports, identified in the POT, are in place and available in working order, or have been ordered and will be in place at the time the waiver participant is placed in the home.

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

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:
i. Evidence of renewal of BLS certification and RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/IHO, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.
iii. Written evidence, in a format acceptable to DHCS/IHO, of on-going contact with the waiver participant's primary care physician for the purpose of informing the primary care physician of the individual's progress, updating, or revising of the POT, and renewal of physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated primary

care physician orders. The updated POT shall be signed by the waiver participant's primary care physician, the RN, the waiver participant and will contain the dates of service.

2. RN case manager, waiver service coordinator, transitional case manager, and/or supervisor acting as the supervisor for a HCBS Waiver LVN:

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current license to practice as an RN in the State of California.
ii. Current BLS certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience providing case management, service coordination, and/or supervision or delegating nursing care tasks to an LVN or other subordinate staff.
iv. Written summary, in a format acceptable to DHCS/IHO, of nursing care tasks that have been delegated to the LVN.

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

i. Evidence of renewal of BLS certification and RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/IHO, of all case management, service coordination and/or supervisory activities which shall include all of the following:

A. Evaluation of the LVN's theoretical knowledge and manual skills needed to care for the individual for whom services have been requested.

B. The training provided to the LVN, as needed, to ensure appropriate care to the waiver participant for whom services have been requested.

C. Monitoring of the care rendered by the LVN, which shall include validation of post-training performance.

D. Any change in the nursing care tasks delegated to the LVN.

E. Evaluation of the case management and/or waiver coordination activities provided.
iii. Written evidence of ongoing contact with the waiver participant's primary care physician, as specified in section B., subsection 1(b)(iii), "requirements of the HCBS Waiver RN," above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the HCBS Waiver RN," above.

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation Services

Provider Category:
Individual
Provider Type:
HCBS Benefit Provider - Marriage and Family Therapist
Provider Qualifications
License *(specify):*

HCBS Benefit Provider - Marriage and Family Therapist
BPC §§4980– 4989
Title 16, §§1829-1848
Certificate *(specify):*

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

Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a MFT. Under the HCBS Waiver, the role of a MFT as a HCBS IHO Waiver Service Provider is to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Accessibility Adaptations (EAA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Transitional Case Management (TCM)

A MFT who functions as a HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a MFT in the State of California.

2. Have work experience that includes, at least a minimum of 1000 hours experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The MFT must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management services consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO and within the MFT's scope of practice as follows:

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

b. Within the MFT's scope of practice, facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the MFT's scope of practice. The POT is updated and signed by the primary care physician no less frequently than once every six months
CBS Waiver Standards of Participation

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation Services

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

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

A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the HCBS IHO Waiver, the role of a LCSW as a HCBS IHO Waiver Service Provider is to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Accessibility Adaptations (EAA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Transitional Case Management (TCM)

A LCSW who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a LCSW in the State of California.

2. Have work experience that includes, at least, a minimum of 1000 hours of providing case management services to the elderly and/or persons with disabilities living in the community.

3. The Licensed Clinical Social Worker must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management/coordination or transitional case management services within the scope of practice of a LCSW consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO, as follows:

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

b. Facilitate the process of assessing the beneficiary at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the beneficiary's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the beneficiary, as determined by the primary care physician. Assist the beneficiary in accessing medical care services that are beyond the LCSW's scope of practice. The POT is updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation Services

Provider Category:
Agency
Provider Type:
Professional Corporation
Provider Qualifications

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

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

A Professional Corporation is a provider that employs individuals who provide services authorized under the HCBS IHO Waiver and is enrolled as an HCBS IHO Waiver Professional Corporation provider in the HCBS IHO Waiver, and meets and maintains the SOP minimal qualifications for a Professional Corporation. Under the HCBS IHO Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Accessibility Adaptations (EAA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Transitional Case Management (TCM)

1. The following are the licensed persons permitted to provide the above listed services as Professional Corporations to waiver participants under the terms of the HCBS IHO Waiver:

a. Licensed Psychologists (See Business and Professions Code section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;

b. Licensed Clinical Social Workers (LCSW) (See Business and Professions Code section 4996, et seq.); operating a Professional Corporation pursuant to Corporations Code section 13400, et seq., and

c. Marriage and Family Therapists (MFT) (See Business and Professions Code section 4980, et seq.) operating as a Professional Corporation pursuant to Corporations Code section 13400, et seq.

2. A Professional Corporation who functions as a HCBS IHO Waiver Service Provider shall:

a. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to Corporations Code section 13400, et seq., or if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation. Good standing of a domestic or foreign professional corporation must be maintained as long as the professional

corporation is enrolled as an HCBS IHO Waiver provider. All Professional Corporations enrolling as HCBS IHO Waiver providers must provide a Certificate of Status of good standing to do business in the State of California (available from the Secretary of State's Office) upon enrollment and provide a current certificate of registration (pursuant to Corporations Code section 13401(b)) provided by the governmental agency regulating the profession. Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the certificate of registration. (Corporations Code section 13401(b)).

b. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.

c. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

i. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by DHCS/IHO. The professional corporation must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

ii. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 hours of experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

The Professional Corporation must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS/IHO.

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

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

ii. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the licensed person's scope of practice. The POT must be updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation Services

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - Licensed Psychologist

Provider Qualifications

License *(specify):*

BPC §§2909 et seq.

Title 16, §§1380 et seq.

Certificate *(specify):*

Other Standard *(specify):*

HCBS IHO Waiver Standards of Participation

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

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Accessibility Adaptations (EAA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Transitional Case Management (TCM)

A Licensed Psychologist who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California.

2. Have work experience that includes, at least a minimum of 1000 hours of experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The Licensed Psychologist must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management services within the scope of practice of a Licensed Psychologist consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO as follows:

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

b. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice. The POT must be updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Psychology

Frequency of Verification:

Biennially

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation Services

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

Other Standard *(specify):*

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

Appendix C: Participant Services

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

Service Type: 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):*
HCBS IHO Waiver Standards of Participation

A Non-Profit Organization is a California service entity organized and operated under the United States Internal Revenue Code Section 501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBS IHO Waiver SOP and Medi-Cal Provider requirements may provide HCBS IHO Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified supervised unlicensed staff.

A Non-Profit Organization may provide the following HCBS IHO Waiver services:
• Case Management/Coordination (CM/C)

• Community Transition Services (CTS)
• Environmental Accessibility Adaptations (EEA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response Systems (PERS)
• Transitional Case Management (TCM)
• Home Respite
• Waiver Personal Care Services (WPCS)

Minimum qualifications for a Non-Profit Organization functioning as an HCBS IHO Waiver Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program possesses a Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community, or have al least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. The Non-Profit Organization shall maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. The Non-Profit Organization is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. The Non-Profit Organization is responsible for providing training and/or in-services to staff eligible to provide HCBS IHO Waiver services and at least annually reviews the HCBS IHO Waiver services requirements. Training of HCBS IHO Waiver service providers must be specific to the conditions and care of HCBS IHO Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBS IHO Waiver.

8. The Non-Profit Organization is responsible for the maintenance of waiver participant case documentation and financial records which support the claims for waiver services for a minimum period of three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), License Psychologist and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within his/her scope of licensure in the State of California. The Non-Profit Organization must maintain records of licensing for inspection and review by DHCS/IHO. The Non-Profit Organization must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM, TCM, CTS, HS, EAA, PERS, and/or MEOE to the elderly and/or persons with disabilities living in the community.

The Non-Profit Organization must maintain records and documentation of any and all requirements

of the waiver/SOP for inspection and review by DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/IHO within 30 days of the change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS/IHO.

10. Employs qualified professional providers to provide HCBS IHO CM/C, CTS, HS, EAA, PERS, TCM, and/or MEOE services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Must have earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM and/or MEOE services to the elderly and/or persons with disabilities living in the community. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation Services, which may include activities commonly described as peer mentoring, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher with 1000 hours experience in providing supervision to providers of services to the elderly and/or persons with disabilities living in the community, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have at least 1000 hours work experience in providing services to the elderly and/or persons with disabilities living in the community, or:

b. Have two years of experience in providing services to the elderly and/or persons with disabilities living in the community, through an organization or agency, or

c. Have one year experience as a Peer Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or in the community, through and organization or agency.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS/IHO.

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

a. Develop the IHO Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest, the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interests and medical care needs are addressed. The POT will identify all the choice and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and

b. Facilitate the process of collaboration and assessment with the participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician and/or the case manager/coordinator of the participant's status to update or revise the POT as

directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and care needs of the participant. Assist the participant in accessing services that are beyond the licensed professional's scope of practice, credentialing, or experience. The POT must be updated and signed by the participant and the primary care physician no less frequently than once every six months.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's Registry of Charitable Trusts

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

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 temporary medical and/or non-medical care supervision provided to the participant in their own home to do the following:

1. Assist family members in maintaining the participant at home;

2. Provide appropriate care and supervision to protect the participant's safety in the absence of family members or caregivers;

3. Relieve family members from the constantly demanding responsibility of caring for a participant; and

4. Attend to the participant's medical and non-medical needs and other ADLs, which would ordinarily be performed by the service provider or family member.

The Home Respite benefit, as authorized, is to temporarily replace non-medical care that was provided to the participant by his/her legal representative/legally responsible adult(s), and/or circle of support for a scheduled period of time as previously authorized by DHCS/IHO.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
DHCS/IHO will not authorize direct care services or any combination of direct care and protective supervision services exceeding 24 hours of care per day under this waiver regardless of the funding source. Direct care services include State Plan services, such as personal care services, adult or pediatric day health care, In-Home Supportive Services (IHSS) Plus Waiver services, PDN, shared PDN, and/or direct care authorized by the participant's private insurance. Direct care is hands on care to support the care needs of the waiver participant. Protective supervision is observing the participant's behavior in order to safeguard the participant against injury, hazard, or accident.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:

Agency

Provider Type:
Home Health Agency (HHA) - Licensed Vocational Nurse (LVN)
Provider Qualifications
License *(specify)*:
HHA Title 22, §74659 et seq.
LVN BPC §§2859-2873.7
Title 22, §51069;
Certificate *(specify)*:

Other Standard *(specify)*:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:
Individual
Provider Type:
Waiver Personal Care Service (WPCS) Provider
Provider Qualifications
License *(specify)*:
NA
Certificate *(specify)*:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:
Agency
Provider Type:
Non-Profit Agency

Provider Qualifications

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

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

A Non-Profit Organization is a California service entity organized and operated under the United States Internal Revenue Code Section 501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBS IHO Waiver SOP and Medi-Cal Provider requirements may provide HCBS IHO Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified supervised unlicensed staff.

A Non-Profit Organization may provide the following HCBS IHO Waiver services:
• Case Management/Coordination (CM/C)
• Community Transition Services (CTS)
• Environmental Accessibility Adaptations (EEA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response Systems (PERS)
• Transitional Case Management (TCM)
• Home Respite
• Waiver Personal Care Services (WPCS)

Minimum qualifications for a Non-Profit Organization functioning as an HCBS IHO Waiver Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program possesses a Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community, or have al least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. The Non-Profit Organization shall maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. The Non-Profit Organization is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. The Non-Profit Organization is responsible for providing training and/or in-services to staff eligible to provide HCBS IHO Waiver services and at least annually reviews the HCBS IHO Waiver services requirements. Training of HCBS IHO Waiver service providers must be specific to the conditions and care of HCBS IHO Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBS IHO Waiver.

8. The Non-Profit Organization is responsible for the maintenance of waiver participant case documentation and financial records which support the claims for waiver services for a minimum period of three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), License Psychologist and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within his/her scope of licensure in the State of California. The Non-Profit Organization must maintain records of licensing for inspection and review by DHCS/IHO. The Non-Profit Organization must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM, TCM, CTS, HS, EAA, PERS, and/or MEOE to the elderly and/or persons with disabilities living in the community.

The Non-Profit Organization must maintain records and documentation of any and all requirements of the waiver/SOP for inspection and review by DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/IHO within 30 days of the change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS/IHO.

10. Employs qualified professional providers to provide HCBS IHO CM/C, CTS, HS, EAA, PERS, TCM, and/or MEOE services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Must have earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM and/or MEOE services to the elderly and/or persons with disabilities living in the community.
The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation Services, which may include activities commonly described as peer mentoring, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher with 1000 hours experience in providing supervision to providers of services to the elderly and/or persons with disabilities living in the community, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have at least 1000 hours work experience in providing services to the elderly and/or persons with disabilities living in the community, or:

b. Have two years of experience in providing services to the elderly and/or persons with disabilities living in the community, through an organization or agency, or

c. Have one year experience as a Peer Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or in the community, through and organization or agency.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS/IHO.

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

a. Develop the IHO Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest, the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interests and medical care needs are addressed. The POT will identify all the choice and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and

b. Facilitate the process of collaboration and assessment with the participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician and/or the case manager/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and care needs of the participant. Assist the participant in accessing services that are beyond the licensed professional's scope of practice, credentialing, or experience. The POT must be updated and signed by the participant and the primary care physician no less frequently than once every six months.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's Registry of Charitable Trusts

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - Licensed Vocational Nurse (LVN)

Provider Qualifications

License *(specify):*

BPC §§2859-2873.7
Title 22, §51069;

Certificate *(specify):*

Other Standard *(specify):*

HCBS IHO Waiver Standards of Participation

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

• Private Duty Nursing (PDN)
• Respite Care

1. Definitions:
a. "HCBS Waiver Nurse Provider – Licensed Vocational Nurse (LVN)" means a LVN who provides HCBS Waiver LVN services, as defined in subsection A.2, below, and, in this capacity, is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

A HCBS Waiver LVN may be a parent, stepparent, foster parent of a minor, a spouse, or legal guardian of the individual only under the following circumstances: there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained by only using this individual. DHCS/IHO may require additional documentation to support requests of this nature. Documentation required before DHCS/IHO can authorize such request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not hired or refused employment, if offered.

b. "HCBS Waiver LVN services" means private duty nursing services, as described the in HCBS IHO Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an HCBS Waiver LVN, as defined in subsection A.1, above, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

c. "Private duty nursing services" means services provided by a LVN, which are more individual and continuous than those routinely available through a home health agency as in part-time or intermittent care on a limited basis.

d. "Education and/or training requirements" means any type of formal instruction related to the care needs of the individual for whom services are being requested. Examples of this could include certifications in a particular field, appropriate to the licensure status of the nurse; or continuing education units in the needs of the waiver participant such as wound or pain management.

Requirements of the HCBS Waiver LVN:

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

a. Current license to practice as an LVN in the State of California.

b. Current BLS certification.

c. Name and RN license number of the individual who will be providing ongoing supervision. Such supervision shall be required at a minimum of two hours per calendar month.

d. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, as specified in section B, subsection 1(a)(iii), "requirements of the HCBS Waiver LVN", above.

e. Copy of the detailed POT that reflects the RN nursing assessment of the waiver participant and the primary care physician's orders. The POT shall be signed by the supervising RN, the waiver participant's primary care physician, the waiver participant, and the LVN.

f. Written home safety evaluation, in a format acceptable to DHCS/IHO, as specified in section B, subsection 1(a)(vi), "requirements of the HCBS Waiver LVN," above.

g. Medical information, as specified in section B., subsection 1(a)(vii), "requirements of the "HCBS Waiver LVN provider," above.

2. All subsequent reauthorization TARs shall be accompanied by all of the following

documentation, as specified:
a. Evidence of renewal of BLS certification and LVN licensure prior to expiration.

b. Written evidence, in a format acceptable to DHCS/IHO, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.

c. Copy of the updated POT that reflects the ongoing RN nursing assessment and updated primary care physician's orders. The POT shall be signed by the supervising RN, the waiver participant's primary care physician, the waiver participant, and the LVN, and shall contain the dates of service.

3. A TAR or similar request must be approved in advance by DHCS/IHO and shall be required for each HCBS Waiver LVN service request. Initial authorization shall be granted for a period of up to 90 days, and reauthorization shall be granted for periods of up to 180 days.

4. The HCBS Waiver LVN shall agree to notify DHCS/IHO and the waiver participant or his/her legal guardian, in writing, at least thirty (30) days prior to the effective date of termination when the HCBS Waiver LVN intends to terminate HCBS, LVN services. This time period may be less than thirty (30) days if there are immediate issues of health and safety for either the nurse or the waiver participant, as determined by the DHCS/IHO.

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home Respite

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

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

Other Standard *(specify)*:

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home Respite

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

Other Standard *(specify):*

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home Respite

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

Other Standard *(specify):*
County IHSS Program Standards & HCBS IHO 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 HCBS IHO Waiver Employment Agency provider in the HCBS IHO Waiver, and meets and maintains the Standards of Participation (SOP) minimal qualifications for an Employment Agency.

Under the HCBS IHO Waiver, the role of the Employment Agency as an HCBS IHO Waiver Service Provider is to provide:
• WPCS.
• Respite
1. The minimal qualifications for the Employment Agency will include:
a. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.
b. Must maintain a bond or deposit in lieu of bond in accordance with the Employment Agency,

Employment Counseling, and Job Listing Services Act, Title 2.91, Chapters 1-8 (Civil Code section 1812.500 through 1812.544) of the Civil Code ("the Act"), with the California Secretary of State's Office, unless specifically exempted under Title 2.91 of the Civil Code. The Employment Agency shall submit evidence of the filing of its bond prior to enrollment as an HCBS IHO Waiver provider. If a Employment Agency claims exemption from the bond requirements of "the Act", the Employment Agency owner or officer (as authorized by the Employment Agency) shall provide a declaration under penalty of perjury that its operations and/or business do not require the filing of a bond pursuant to the Act and specifically identify the exemption under the Act that applies to the Employment Agency. The declaration under penalty of perjury must also contain the date, place of signature (city or county), and signature of the officer or owner.

c. Provide training and/or in-services to all its HCBS IHO Waiver providers and review training at least annually for a minimum of 8 hours. Training of HCBS IHO Waiver service providers must be specific to the conditions and care of HCBS IHO Waiver beneficiaries served by the agency. This training shall not be reimbursed by this waiver and shall include information in any one or more of the following areas:

- Companionship services
- Activities of daily living
- Basic first aid
- Bowel and bladder care
- Accessing community services
- Basic nutritional care
- Body mechanics

2. Employ individuals who will render HCBS IHO Waiver services to the beneficiaries as authorized by DHCS/IHO and, who meet the following criteria:

a. Employ individuals who have work experience that includes:

b. A minimum of 1000 hours of experience within the previous two years in providing companionship, assistance with Activities of Daily Living (ADLs), basic first aid, bowel and bladder care, and assistance with accessing community services to the physically and/or developmentally disabled community.

3. Comply with all pertinent regulations regarding the provision of Personal Care Services under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, section 51183.

4. Comply with all pertinent regulations regarding Personal Care Service Providers under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, section 51204.

5. Comply with all pertinent statutes regarding the Personal Care Services Program as outlined in the Welfare and Institutions Code sections 12300, et seq., 14132.95, and 14132.97.

6. Comply with the terms and conditions provided in the waiver under which the services are provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home Respite

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - Registered Nurse (RN)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

HCBS IHO Waiver Standards of Participation

Under the HCBS IHO Waiver, the role of the HCBS Waiver Nurse Provider – Registered Nurse (RN) is to provide:

- Case Management/Coordination (CM/C)
- Community Transition Service (CTS)
- Environmental Adaptations (EAA)
- Family Training
- Habilitation Services (HS)
- Medical Equipment Operating Expenses (MEOE)
- Private Duty Nursing (PDN)
- Respite Care
- Transitional Case Management (TCM)

Definitions:

a. "HCBS Waiver Nurse Provider – Registered Nurse (RN) " means a RN, who provides HCBS Waiver RN services, as defined in subsection A.2, below, and, in this capacity, is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

A HCBS Waiver RN may be a parent, stepparent, foster parent of a minor, a spouse, or legal guardian of the individual only under the following circumstances: there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained by only using this individual. DHCS/IHO may require additional documentation to support requests of this nature. Documentation required before DHCS/IHO can authorize such request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as a posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not hired or refused employment, if offered.

b. "HCBS Waiver RN services" means private duty nursing services, as described the in HCBS IHO Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an HCBS Waiver RN, as defined in subsection A.1, above, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

c. "Private duty nursing services" means services provided by a RN, which are more individual and continuous than those routinely available through a home health agency as in part-time or intermittent care on a limited basis.

d. "Medi-Cal Consultant" means either a RN or Physician, who is licensed to practice in the State and is an employee of DHCS/IHO.

e. "Education and/or training requirements" means any type of formal instruction related to the care needs of the individual for whom services are being requested. Examples of this could include certifications in a particular field, appropriate to the licensure status of the nurse; or continuing education units in the needs of the waiver participant, such as wound or pain management.

f. "Evaluation of theoretical knowledge and manual skills" means an assessment conducted by the RN of the licensed vocational nurse (LVN) in which the LVN is able to demonstrate competency in the provision of skilled nursing services. Examples of this could include having the LVN verbalize requirements for a certain procedure or process; having the RN review a certain task, demonstrate the task and then observing the LVN perform the tasks as prescribed on the POT. This evaluation would need to be documented and provided to DHCS/IHO as indicated.
Requirements of the HCBS Waiver RN:
1. Registered Nurse (RN) acting as the direct care provider:
a. The initial Treatment Authorization Request (TAR) shall be accompanied by all of the following documentation:
i. Current license to practice as a RN in the State of California.
ii. Current Basic Life Support (BLS) certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, which shall include at least one of the following:

A. A minimum of 1000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.

B. A minimum of 2000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT.

C. A minimum of 2000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) specified on the TAR and POT.

D. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS/IHO, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specified on the TAR and POT.

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

A. The appropriateness of the nursing assessment and interventions shall be determined by the Medi-Cal consultant based upon the waiver participant's medical condition and care need(s).

B. The POT shall be signed by the waiver participant, the RN, and the waiver participant's primary care physician, and shall contain the dates of service.

v. Signed release form from the waiver participant's primary care physician, which shall specify both of the following:
A. The primary care physician has knowledge that the RN providing care to the waiver participant is doing so without the affiliation of a home health agency or other licensed health care agency of record.

B. The primary care physician is willing to accept responsibility for the care rendered to the waiver participant.

vi. Written home safety evaluation, in a format acceptable to DHCS/IHO that demonstrates that the waiver participant's home environment supports the health and safety of the individual. This documentation shall include all of the following:
A. The area where the waiver participant will be cared for will accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies necessary to maintain the individual in the home in comfort and safety, and to facilitate the nursing care required.

B. Primary and back-up utility, communication, and fire safety systems and devices are installed and available in working order, which shall include grounded electrical outlets, smoke detectors, fire extinguisher, telephone, and notification of utility, emergency, and rescue systems that a person with

special needs resides in the home.

C. The home complies with local fire, safety, building, and zoning ordinances, and the number of persons residing in the home does not exceed that permitted by such ordinances.

D. All medical equipment, supplies, primary and back-up systems, and other services and supports, identified in the POT, are in place and available in working order, or have been ordered and will be in place at the time the waiver participant is placed in the home.

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

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:
i. Evidence of renewal of BLS certification and RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/IHO, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.
iii. Written evidence, in a format acceptable to DHCS/IHO, of on-going contact with the waiver participant's primary care physician for the purpose of informing the primary care physician of the individual's progress, updating, or revising of the POT, and renewal of physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated primary care physician orders. The updated POT shall be signed by the waiver participant's primary care physician, the RN, the waiver participant and will contain the dates of service.

2. RN case manager, waiver service coordinator, transitional case manager, and/or supervisor acting as the supervisor for a HCBS Waiver LVN:

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current license to practice as an RN in the State of California.
ii. Current BLS certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience providing case management, service coordination, and/or supervision or delegating nursing care tasks to an LVN or other subordinate staff.
iv. Written summary, in a format acceptable to DHCS/IHO, of nursing care tasks that have been delegated to the LVN.

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

i. Evidence of renewal of BLS certification and RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/IHO, of all case management, service coordination and/or supervisory activities which shall include all of the following:

A. Evaluation of the LVN's theoretical knowledge and manual skills needed to care for the individual for whom services have been requested.

B. The training provided to the LVN, as needed, to ensure appropriate care to the waiver participant for whom services have been requested.

C. Monitoring of the care rendered by the LVN, which shall include validation of post-training performance.

D. Any change in the nursing care tasks delegated to the LVN.

E. Evaluation of the case management and/or waiver coordination activities provided.
iii. Written evidence of ongoing contact with the waiver participant's primary care physician, as specified in section B., subsection 1(b)(iii), "requirements of the HCBS Waiver RN," above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the HCBS 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 & HCBS IHO Waiver Standards of Participation

A Personal Care Agency is a provider that employs individuals who provide Waiver Personal Care Services (WPCS), is enrolled as an HCBS IHO Waiver Personal Care Agency provider in the HCBS IHO waiver, and meets and maintains SOP minimal qualifications for a Personal Care Agency. Under the HCBS IHO Waiver, the role of the Personal Care Agency as an HCBS IHO Waiver Service Provider is to provide:
• WPCS
• Respite care

1. The minimal qualifications for the Personal Care Agency will include:
a. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.
b. Must maintain a bond or deposit in lieu of bond in accordance with the Employment Agency, Employment Counseling, and Job Listing Services Act, Title 2.91, Chapters 1-8 (Civil Code section 1812.500 through 1812.544) of the Civil Code, with the Secretary of State's Office, unless specifically exempted under Title 2.91 of the Civil Code. The Personal Care Agency shall submit evidence of the filing of its bond prior to enrollment as an HCBS IHO Waiver provider. If a Personal Care Agency claims exemption from the bond requirements of the Employment Agency, Employment Counseling, and Job Listing Services Act, the Personal Care agency owner or officer shall provide a declaration under penalty of perjury that its operations or business do not require the filing of a bond pursuant to the Employment Agency, Employment Counseling, and Job Listing Services Act and specifically identify the reason why no bond is required. The declaration must also contain the date, place of signature (city or county), and signature of the officer or owner.

2. Provide training and/or in-services to all its HCBS IHO Waiver providers and provide review training at least annually for a minimum of 8 hours. Training of HCBS IHO Waiver service providers must be specific to the conditions and care of HCBS IHO Waiver beneficiaries served by the agency. This training shall not be reimbursed by this waiver and shall include information in

any one or more of the following areas:
• Companionship services
• Activities of daily living
• Basic first aid
• Bowel and bladder care
• Accessing community services
• Basic nutritional care
• Body mechanics

3. Employ individuals who will render Medi-Cal HCBS IHO Waiver services to beneficiaries as authorized by DHCS/IHO and, who meet the following criteria:

a. Employ individuals who have work experience that includes:
A minimum of 1000 hours of experience within the previous two years in providing companionship, assistance with Activities of Daily Living (ADLs), basic first aid, bowel and bladder care, and assistance with accessing community services to the physically and/or developmentally disabled community.

b. The Personal Care Agency must provide and maintain adequate documentation of the minimum hours of work experience for each of its employees for inspection and review by DHCS/IHO.

c. Comply with all pertinent regulations regarding the provision of Personal Care Services under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, section 51183.

d. Comply with all pertinent regulations regarding Personal Care Service Providers under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, section 51204.

e. Comply with all pertinent statutes regarding the Personal Care Services Program as outlined in the Welfare and Institutions Code sections 12300, et seq., 14132.95, and 14132.97.

f. Comply with the terms and conditions provided in the waiver under which the services are provided.

Verification of Provider Qualifications

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

Appendix C: Participant Services

C-1/C-3: 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) and Personal Care 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):*
The WPCS benefit is designed to assist the waiver participant in gaining independence in his/her activities of daily living and preventing social isolation. These services assist the waiver participant in remaining in his/her residence and continuing to be part of the community. WPCS must be described in the participant's primary care physician signed POT, which must be signed by the participant or his/her legal representative/legally responsible adult(s) or circle of support, the participant's primary care physician, and each WPCS provider. A waiver participant must be enrolled in and receiving personal care services through the federally funded State Plan Personal Care program in order to be eligible for WPCS benefits provided by a WPCS provider. If the personal care services are provided through a Personal Care or Employment Agency, then enrollment in the federally funded State Plan Personal Care program is not a requirement for the waiver participant.

The WPCS benefit includes:

• Assistance to Independence in Activities of Daily Living (ADL): Assisting the participant in reaching a self-care goal, the WPCS provider promotes the participant's ability in obtaining and reinforcing his/her highest level of independence in ADLs. The WPCS provider provides assistance and feedback to the participant in an effort to help him/her reach specific self-care goals in performing or directing his/her caregivers in an activity without assistance from others. Services provided by the WPCS provider are verbal cueing, monitoring for safety and completeness, reinforcement of the participant's attempt to complete self-directed activities, advising the primary caregiver of any problems that have occurred; providing information for updating the participant's POT and addressing any self-care activities with an anticipated goal completion date.

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

Provider Requirements

WPCS providers under this waiver are the following:

1. An individual enrolled in the Medi-Cal Program as a WPCS provider who is not otherwise employed by an employment agency, personal care agency, or home health agency and is an individual who is employed directly by the Medi-Cal participant receiving WPCS services under the waiver. Medi-Cal providers are permitted to enroll in the Medi-Cal program as a Personal Care Service provider pursuant to W&I Code section 14132(t) and Title 22, California Code of Regulations (CCR), section 51246. WPCS providers must meet the same criteria for participation in the Medi-Cal program as required for providers of Personal Care Services. If the WPCS provider is also the Personal Care Services provider to the same Medi-Cal participant, and is reimbursed under the State Plan, then that provider must also enroll in the Medi-Cal program as a WPCS provider.

2. An Employment Agency, as defined in the HCBS IHO Waiver SOP;

3. A Personal Care Agency, as defined in the HCBS IHO Waiver SOP;

4. A Home Health Agency (HHA) WPCS provider. Pursuant to the authority under W&I Code section 14132(t) and Title 22, CCR, section 51246, a HHA WPCS provider enrolled in the waiver shall meet the same definition of and criteria for participation as required for participation in the Medi-Cal program. A HHA WPCS provider shall only be reimbursed for WPCS services provided pursuant to the waiver.

5. In-Home Supportive Services (IHSS) Public Authorities, as defined in the HCBS IHO Waiver SOP.

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

Each WPCS provider must submit a written summary with his/her signed Time Report to DHCS/IHO on the 1st and 16th of every month, describing the services they provided to the participant, the effectiveness of any goal-oriented activities, and the participant's response to the services provided. The WPCS provider shall sign each Time Report and certify under penalty of perjury under the laws of the State of California, that the provisions of the services identified in the Time Report were provided by the WPCS provider and that the hours reported are correct.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Employment Agency

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Employment Agency
Provider Qualifications
License *(specify):*
California Business License
Certificate *(specify):*
NA
Other Standard *(specify):*
County IHSS Program Standards & HCBS IHO 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 HCBS IHO Waiver Employment Agency provider in the HCBS IHO Waiver, and meets and maintains the Standards of Participation (SOP) minimal qualifications for an Employment Agency.

Under the HCBS IHO Waiver, the role of the Employment Agency as an HCBS IHO Waiver Service Provider is to provide:
• WPCS.
• Respite
1. The minimal qualifications for the Employment Agency will include:
a. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.
b. Must maintain a bond or deposit in lieu of bond in accordance with the Employment Agency, Employment Counseling, and Job Listing Services Act, Title 2.91, Chapters 1-8 (Civil Code section 1812.500 through 1812.544) of the Civil Code ("the Act"), with the California Secretary of State's Office, unless specifically exempted under Title 2.91 of the Civil Code. The Employment Agency shall submit evidence of the filing of its bond prior to enrollment as an HCBS IHO Waiver provider. If a Employment Agency claims exemption from the bond requirements of "the Act", the Employment Agency owner or officer (as authorized by the Employment Agency) shall provide a declaration under penalty of perjury that its operations and/or business do not require the filing of a bond pursuant to the Act and specifically identify the exemption under the Act that applies to the Employment Agency. The declaration under penalty of perjury must also contain the date, place of signature (city or county), and signature of the officer or owner.
c. Provide training and/or in-services to all its HCBS IHO Waiver providers and review training at least annually for a minimum of 8 hours. Training of HCBS IHO Waiver service providers must be specific to the conditions and care of HCBS IHO Waiver beneficiaries served by the agency. This training shall not be reimbursed by this waiver and shall include information in any one or more of the following areas:
• Companionship services
• Activities of daily living
• Basic first aid
• Bowel and bladder care

• Accessing community services
• Basic nutritional care
• Body mechanics

2. Employ individuals who will render HCBS IHO Waiver services to the beneficiaries as authorized by DHCS/IHO and, who meet the following criteria:
a. Employ individuals who have work experience that includes:
b. A minimum of 1000 hours of experience within the previous two years in providing companionship, assistance with Activities of Daily Living (ADLs), basic first aid, bowel and bladder care, and assistance with accessing community services to the physically and/or developmentally disabled community.

3. Comply with all pertinent regulations regarding the provision of Personal Care Services under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, section 51183.

4. Comply with all pertinent regulations regarding Personal Care Service Providers under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, section 51204.

5. Comply with all pertinent statutes regarding the Personal Care Services Program as outlined in the Welfare and Institutions Code sections 12300, et seq., 14132.95, and 14132.97.

6. Comply with the terms and conditions provided in the waiver under which the services are provided.

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Wavier Personal Care Service (WPCS) Provider
Provider Qualifications

License *(specify):*
NA
Certificate *(specify):*
NA
Other Standard *(specify):*
County IHSS Program Standards & HCBS IHO Waiver Standards

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCS/IHO Nurse Evaluator
Frequency of Verification:
Every 6 months

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Home Health Agency (HHA)
Provider Qualifications
License *(specify):*
Title 22, §§74659 et seq.
Certificate *(specify):*
NA
Other Standard *(specify):*
County IHSS Program Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
DPH Licensing and Certification
Frequency of Verification:
Annually

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Personal Care Agency
Provider Qualifications
License *(specify):*
California Business License
Certificate *(specify):*
NA
Other Standard *(specify):*
County IHSS Program Standards & HCBS IHO Waiver Standards of Participation

A Personal Care Agency is a provider that employs individuals who provide Waiver Personal Care Services (WPCS), is enrolled as an HCBS IHO Waiver Personal Care Agency provider in the HCBS IHO waiver, and meets and maintains SOP minimal qualifications for a Personal Care Agency. Under the HCBS IHO Waiver, the role of the Personal Care Agency as an HCBS IHO Waiver Service Provider is to provide:
• WPCS
• Respite care

1. The minimal qualifications for the Personal Care Agency will include:
a. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.
b. Must maintain a bond or deposit in lieu of bond in accordance with the Employment Agency, Employment Counseling, and Job Listing Services Act, Title 2.91, Chapters 1-8 (Civil Code section 1812.500 through 1812.544) of the Civil Code, with the Secretary of State's Office, unless specifically exempted under Title 2.91 of the Civil Code. The Personal Care Agency shall submit evidence of the filing of its bond prior to enrollment as an HCBS IHO Waiver provider. If a Personal Care Agency claims exemption from the bond requirements of the Employment Agency, Employment Counseling, and Job Listing Services Act, the Personal Care agency owner or officer shall provide a declaration under penalty of perjury that its operations or business do not require the

filing of a bond pursuant to the Employment Agency, Employment Counseling, and Job Listing Services Act and specifically identify the reason why no bond is required. The declaration must also contain the date, place of signature (city or county), and signature of the officer or owner.

2. Provide training and/or in-services to all its HCBS IHO Waiver providers and provide review training at least annually for a minimum of 8 hours. Training of HCBS IHO Waiver service providers must be specific to the conditions and care of HCBS IHO Waiver beneficiaries served by the agency. This training shall not be reimbursed by this waiver and shall include information in any one or more of the following areas:
• Companionship services
• Activities of daily living
• Basic first aid
• Bowel and bladder care
• Accessing community services
• Basic nutritional care
• Body mechanics

3. Employ individuals who will render Medi-Cal HCBS IHO Waiver services to beneficiaries as authorized by DHCS/IHO and, who meet the following criteria:

a. Employ individuals who have work experience that includes:
A minimum of 1000 hours of experience within the previous two years in providing companionship, assistance with Activities of Daily Living (ADLs), basic first aid, bowel and bladder care, and assistance with accessing community services to the physically and/or developmentally disabled community.

b. The Personal Care Agency must provide and maintain adequate documentation of the minimum hours of work experience for each of its employees for inspection and review by DHCS/IHO.

c. Comply with all pertinent regulations regarding the provision of Personal Care Services under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, section 51183.

d. Comply with all pertinent regulations regarding Personal Care Service Providers under the Medi-Cal Program as outlined in the California Code of Regulations, Title 22, section 51204.

e. Comply with all pertinent statutes regarding the Personal Care Services Program as outlined in the Welfare and Institutions Code sections 12300, et seq., 14132.95, and 14132.97.

f. Comply with the terms and conditions provided in the waiver under which the services are provided.

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Non-Profit Agency
Provider Qualifications

License *(specify):*
Business license, appropriate for the services purchased
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

A Non-Profit Organization is a California service entity organized and operated under the United States Internal Revenue Code Section 501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBS IHO Waiver SOP and Medi-Cal Provider requirements may provide HCBS IHO Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified supervised unlicensed staff.

A Non-Profit Organization may provide the following HCBS IHO Waiver services:
• Case Management/Coordination (CM/C)
• Community Transition Services (CTS)
• Environmental Accessibility Adaptations (EEA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response Systems (PERS)
• Transitional Case Management (TCM)
• Home Respite
• Waiver Personal Care Services (WPCS)

Minimum qualifications for a Non-Profit Organization functioning as an HCBS IHO Waiver Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program possesses a Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community, or have al least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. The Non-Profit Organization shall maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. The Non-Profit Organization is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. The Non-Profit Organization is responsible for providing training and/or in-services to staff eligible to provide HCBS IHO Waiver services and at least annually reviews the HCBS IHO Waiver services requirements. Training of HCBS IHO Waiver service providers must be specific to the conditions and care of HCBS IHO Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBS IHO Waiver.

8. The Non-Profit Organization is responsible for the maintenance of waiver participant case documentation and financial records which support the claims for waiver services for a minimum period of three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker

(LCSW), License Psychologist and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within his/her scope of licensure in the State of California. The Non-Profit Organization must maintain records of licensing for inspection and review by DHCS/IHO. The Non-Profit Organization must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM, TCM, CTS, HS, EAA, PERS, and/or MEOE to the elderly and/or persons with disabilities living in the community.

The Non-Profit Organization must maintain records and documentation of any and all requirements of the waiver/SOP for inspection and review by DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/IHO within 30 days of the change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS/IHO.

10. Employs qualified professional providers to provide HCBS IHO CM/C, CTS, HS, EAA, PERS, TCM, and/or MEOE services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Must have earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM and/or MEOE services to the elderly and/or persons with disabilities living in the community.
The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation Services, which may include activities commonly described as peer mentoring, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher with 1000 hours experience in providing supervision to providers of services to the elderly and/or persons with disabilities living in the community, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have at least 1000 hours work experience in providing services to the elderly and/or persons with disabilities living in the community, or:

b. Have two years of experience in providing services to the elderly and/or persons with disabilities living in the community, through an organization or agency, or

c. Have one year experience as a Peer Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or in the community, through and organization or agency.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS/IHO.

12. The Non-Profit Organization must provide Case Management/Coordination services consistent

with the participant's choice and interests, the primary care physician's orders and the IHO Waiver Plan of Treatment (POT) within the licensed provider's scope of practice and/or the qualified professional's experience as follows:

a. Develop the IHO Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest, the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interests and medical care needs are addressed. The POT will identify all the choice and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and

b. Facilitate the process of collaboration and assessment with the participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician and/or the case manager/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and care needs of the participant. Assist the participant in accessing services that are beyond the licensed professional's scope of practice, credentialing, or experience. The POT must be updated and signed by the participant and the primary care physician no less frequently than once every six months.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's Registry of Charitable Trusts

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

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: a) security deposits that are required to obtain a lease on an apartment or home; b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; e) moving expenses; f) necessary home accessibility adaptations; and g) activities to assess, arrange for, and procure needed resources. Community Transition Services are furnished only to the extent that they are reasonable and necessary. Documentation must be clearly identified in the POT that these services cannot be obtained from other sources as determined through the POT development process. Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely recreational purposes.

The lifetime maximum allowed cost for Community Transition Services is $5,000.00. The DHCS/IHO NE will explain to the participant the guidelines of the Community Transition Services under the waiver. The use of this service will necessarily result in a reduction in other waiver services the participant may receive during the same year Community Transition Services are authorized. The participant's waiver costs must be cost neutral to the inpatient alternative. The participant should understand the possible fiscal impact of receiving this service at the time of request for the Community Transition Services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Community Transition Services are payable up to a total lifetime maximum amount of $5,000.00.

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
Individual	HCBS Benefit Provider - Licensed Clinical Social Worker (LCSW)
Agency	Non-Profit Agency
Agency	Professional Corporation
Agency	Home Health Agency (HHA) - Registered Nurse (RN)

Provider Category	Provider Type Title
Individual	HCBS Benefit Provider - Licensed Psychologist
Individual	HCBS Waiver Nurse Provider - Registered Nurse (RN)
Individual	HCBS Benefit Provider - Marriage and Family Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Individual
Provider Type:
HCBS Benefit Provider - Licensed Clinical Social Worker (LCSW)
Provider Qualifications
License *(specify):*
BPC §§4990-4998.7
Title 16, §§1870-1881
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation
A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the HCBS IHO Waiver, the role of a LCSW as a HCBS IHO Waiver Service Provider is to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Accessibility Adaptations (EAA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Transitional Case Management (TCM)

A LCSW who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a LCSW in the State of California.

2. Have work experience that includes, at least, a minimum of 1000 hours of providing case management services/coordination to the elderly and/or persons with disabilities living in the community.

3. The Licensed Clinical Social Worker must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management or transitional case management services within the scope of practice of a LCSW consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO, as follows:

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

b. Facilitate the process of assessing the beneficiary at the frequency described in the POT for

progress and response to the POT. Inform the primary care physician of the beneficiary's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the beneficiary, as determined by the primary care physician. Assist the beneficiary in accessing medical care services that are beyond the LCSW's scope of practice. The POT is updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Agency
Provider Type:
Non-Profit Agency
Provider Qualifications

License *(specify):*
Business license, appropriate for the services purchased
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

A Non-Profit Organization is a California service entity organized and operated under the United States Internal Revenue Code Section 501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBS IHO Waiver SOP and Medi-Cal Provider requirements may provide HCBS IHO Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified supervised unlicensed staff.

A Non-Profit Organization may provide the following HCBS IHO Waiver services:
• Case Management/Coordination (CM/C)
• Community Transition Services (CTS)
• Environmental Accessibility Adaptations (EEA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response Systems (PERS)
• Transitional Case Management (TCM)
• Home Respite
• Waiver Personal Care Services (WPCS)

Minimum qualifications for a Non-Profit Organization functioning as an HCBS IHO Waiver Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program possesses a Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community, or have al least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. The Non-Profit Organization shall maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. The Non-Profit Organization is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. The Non-Profit Organization is responsible for providing training and/or in-services to staff eligible to provide HCBS IHO Waiver services and at least annually reviews the HCBS IHO Waiver services requirements. Training of HCBS IHO Waiver service providers must be specific to the conditions and care of HCBS IHO Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBS IHO Waiver.

8. The Non-Profit Organization is responsible for the maintenance of waiver participant case documentation and financial records which support the claims for waiver services for a minimum period of three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), License Psychologist and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within his/her scope of licensure in the State of California. The Non-Profit Organization must maintain records of licensing for inspection and review by DHCS/IHO. The Non-Profit Organization must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM, TCM, CTS, HS, EAA, PERS, and/or MEOE to the elderly and/or persons with disabilities living in the community.

The Non-Profit Organization must maintain records and documentation of any and all requirements of the waiver/SOP for inspection and review by DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/IHO within 30 days of the change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS/IHO.

10. Employs qualified professional providers to provide HCBS IHO CM/C, CTS, HS, EAA, PERS, TCM, and/or MEOE services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Must have earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM and/or MEOE services to the elderly and/or persons with disabilities living in the community.
The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation Services, which may include activities commonly described as peer mentoring, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher with 1000 hours experience in providing supervision to providers of services to the elderly and/or persons with disabilities living in the community, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have at least 1000 hours work experience in providing services to the elderly and/or persons with disabilities living in the community, or:

b. Have two years of experience in providing services to the elderly and/or persons with disabilities living in the community, through an organization or agency, or

c. Have one year experience as a Peer Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or in the community, through and organization or agency.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS/IHO.

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

a. Develop the IHO Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest, the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interests and medical care needs are addressed. The POT will identify all the choice and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and

b. Facilitate the process of collaboration and assessment with the participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician and/or the case manager/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and care needs of the participant. Assist the participant in accessing services that are beyond the licensed professional's scope of practice, credentialing, or experience. The POT must be updated and signed by the participant and the primary care physician no less frequently than once every six months.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's Registry of Charitable Trusts

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Agency
Provider Type:
Professional Corporation
Provider Qualifications
License *(specify):*
CC §13401(b)
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide services authorized under the HCBS IHO Waiver and is enrolled as an HCBS IHO Waiver Professional Corporation provider in the HCBS IHO Waiver, and meets and maintains the SOP minimal qualifications for a Professional Corporation. Under the HCBS IHO Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Accessibility Adaptations (EAA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Transitional Case Management (TCM)

1. The following are the licensed persons permitted to provide the above listed services as Professional Corporations to waiver participants under the terms of the HCBS IHO Waiver:

a. Licensed Psychologists (See Business and Professions Code section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;

b. Licensed Clinical Social Workers (LCSW) (See Business and Professions Code section 4996, et seq.); operating a Professional Corporation pursuant to Corporations Code section 13400, et seq., and

c. Marriage and Family Therapists (MFT) (See Business and Professions Code section 4980, et seq.) operating as a Professional Corporation pursuant to Corporations Code section 13400, et seq.

2. A Professional Corporation who functions as a HCBS IHO Waiver Service Provider shall:

a. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to Corporations Code section 13400, et seq., or if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation. Good standing of a domestic or foreign professional corporation must be maintained as long as the professional corporation is enrolled as an HCBS IHO Waiver provider. All Professional Corporations enrolling as HCBS IHO Waiver providers must provide a Certificate of Status of good standing to do business in the State of California (available from the Secretary of State's Office) upon enrollment and provide a current certificate of registration (pursuant to Corporations Code section 13401(b)) provided by the governmental agency regulating the profession. Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the certificate of registration. (Corporations Code section 13401(b)).

b. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.

c. Employ licensed persons as specified above who will render waiver services to waiver

participants as requested and authorized and who meet the following criteria:

i. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by DHCS/IHO. The professional corporation must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

ii. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 hours of experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

The Professional Corporation must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS/IHO.

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

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

ii. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the licensed person's scope of practice. The POT must be updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

NA

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - Licensed Psychologist

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

NA

Other Standard *(specify):*

HCBS IHO Waiver Standards of Participation

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

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Accessibility Adaptations (EAA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Transitional Case Management (TCM)

A Licensed Psychologist who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California.

2. Have work experience that includes, at least a minimum of 1000 hours of experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The Licensed Psychologist must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management services within the scope of practice of a Licensed Psychologist consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO as follows:

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

b. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice. The POT must be updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

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

License *(specify):*
BPC §§2725 et seq.
Title 22, §51067;
Title 16, §1409-1419.4
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of ParticipationHCBS IHO Waiver Standards of Participation

Under the HCBS IHO Waiver, the role of the HCBS Waiver Nurse Provider – Registered Nurse (RN) is to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Adaptations (EAA)
• Family Training
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Private Duty Nursing (PDN)
• Respite Care
• Transitional Case Management (TCM) 1.

Definitions:
a. "HCBS Waiver Nurse Provider – Registered Nurse (RN) " means a RN, who provides HCBS Waiver RN services, as defined in subsection A.2, below, and, in this capacity, is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

A HCBS Waiver RN may be a parent, stepparent, foster parent of a minor, a spouse, or legal guardian of the individual only under the following circumstances: there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained by only using this individual. DHCS/IHO may require additional documentation to support requests of this nature. Documentation required before DHCS/IHO can

authorize such request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as a posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not hired or refused employment, if offered.

b. “HCBS Waiver RN services” means private duty nursing services, as described the in HCBS IHO Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an HCBS Waiver RN, as defined in subsection A.1, above, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

c. “Private duty nursing services” means services provided by a RN, which are more individual and continuous than those routinely available through a home health agency as in part-time or intermittent care on a limited basis.

d. “Medi-Cal Consultant” means either a RN or Physician, who is licensed to practice in the State and is an employee of DHCS/IHO.

e. “Education and/or training requirements” means any type of formal instruction related to the care needs of the individual for whom services are being requested. Examples of this could include certifications in a particular field, appropriate to the licensure status of the nurse; or continuing education units in the needs of the waiver participant, such as wound or pain management.

f. “Evaluation of theoretical knowledge and manual skills” means an assessment conducted by the RN of the licensed vocational nurse (LVN) in which the LVN is able to demonstrate competency in the provision of skilled nursing services. Examples of this could include having the LVN verbalize requirements for a certain procedure or process; having the RN review a certain task, demonstrate the task and then observing the LVN perform the tasks as prescribed on the POT. This evaluation would need to be documented and provided to DHCS/IHO as indicated.
Requirements of the HCBS Waiver RN:
1. Registered Nurse (RN) acting as the direct care provider:
a. The initial Treatment Authorization Request (TAR) shall be accompanied by all of the following documentation:
i. Current license to practice as a RN in the State of California.
ii. Current Basic Life Support (BLS) certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, which shall include at least one of the following:

A. A minimum of 1000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.

B. A minimum of 2000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT.

C. A minimum of 2000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) specified on the TAR and POT.

D. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS/IHO, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specified on the TAR and POT.

iv. A detailed POT that reflects an appropriate nursing assessment of the waiver participant, interventions, and the primary care physician’s orders.

A. The appropriateness of the nursing assessment and interventions shall be determined by the

Medi-Cal consultant based upon the waiver participant's medical condition and care need(s).

B. The POT shall be signed by the waiver participant, the RN, and the waiver participant's primary care physician, and shall contain the dates of service.

v. Signed release form from the waiver participant's primary care physician, which shall specify both of the following:
A. The primary care physician has knowledge that the RN providing care to the waiver participant is doing so without the affiliation of a home health agency or other licensed health care agency of record.

B. The primary care physician is willing to accept responsibility for the care rendered to the waiver participant.

vi. Written home safety evaluation, in a format acceptable to DHCS/IHO that demonstrates that the waiver participant's home environment supports the health and safety of the individual. This documentation shall include all of the following:
A. The area where the waiver participant will be cared for will accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies necessary to maintain the individual in the home in comfort and safety, and to facilitate the nursing care required.

B. Primary and back-up utility, communication, and fire safety systems and devices are installed and available in working order, which shall include grounded electrical outlets, smoke detectors, fire extinguisher, telephone, and notification of utility, emergency, and rescue systems that a person with special needs resides in the home.

C. The home complies with local fire, safety, building, and zoning ordinances, and the number of persons residing in the home does not exceed that permitted by such ordinances.

D. All medical equipment, supplies, primary and back-up systems, and other services and supports, identified in the POT, are in place and available in working order, or have been ordered and will be in place at the time the waiver participant is placed in the home.

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

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:
i. Evidence of renewal of BLS certification and RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/IHO, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.
iii. Written evidence, in a format acceptable to DHCS/IHO, of on-going contact with the waiver participant's primary care physician for the purpose of informing the primary care physician of the individual's progress, updating, or revising of the POT, and renewal of physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated primary care physician orders. The updated POT shall be signed by the waiver participant's primary care physician, the RN, the waiver participant and will contain the dates of service.

2. RN case manager, waiver service coordinator, transitional case manager, and/or supervisor acting as the supervisor for a HCBS Waiver LVN:

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current license to practice as an RN in the State of California.
ii. Current BLS certification.

iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience providing case management, service coordination, and/or supervision or delegating nursing care tasks to an LVN or other subordinate staff.
iv. Written summary, in a format acceptable to DHCS/IHO, of nursing care tasks that have been delegated to the LVN.

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

i. Evidence of renewal of BLS certification and RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/IHO, of all case management, service coordination and/or supervisory activities which shall include all of the following:

A. Evaluation of the LVN's theoretical knowledge and manual skills needed to care for the individual for whom services have been requested.

B. The training provided to the LVN, as needed, to ensure appropriate care to the waiver participant for whom services have been requested.

C. Monitoring of the care rendered by the LVN, which shall include validation of post-training performance.

D. Any change in the nursing care tasks delegated to the LVN.

E. Evaluation of the case management and/or waiver coordination activities provided.
iii. Written evidence of ongoing contact with the waiver participant's primary care physician, as specified in section B., subsection 1(b)(iii), "requirements of the HCBS Waiver RN," above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the HCBS Waiver RN," above.

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Individual
Provider Type:
HCBS Benefit Provider - Marriage and Family Therapist
Provider Qualifications

License *(specify):*
BPC §§4980-4989
Title 16, §§1829-1848
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a MFT. Under the HCBS Waiver, the role of a MFT as a HCBS IHO Waiver Service Provider is to

provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Accessibility Adaptations (EAA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Transitional Case Management (TCM)

A MFT who functions as a HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a MFT in the State of California.

2. Have work experience that includes, at least a minimum of 1000 hours experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The MFT must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management services consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO and within the MFT's scope of practice as follows:

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

b. Within the MFT's scope of practice, facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the MFT's scope of practice. The POT is updated and signed by the primary care physician no less frequently than once every six months
CBS Waiver Standards of Participation

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

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

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

1. Primary care 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. Either a description of similar equipment used currently or in the past that has demonstrated to be inadequate for the participant and a description of the inadequacy.

3. A Medical Social Worker evaluation and report to evaluate other possible community resources available to provide the requested equipment or service, the availability of the other resources, and any other pertinent recommendations related to the requested equipment or service. This should include the description of the availability of Other Health Coverage (OHC) to provide for the requested equipment or service;

4. Depending on the type of adaptation or modification requested, documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the participant, including any supporting documentation describing the efficacy of the equipment. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the participant describing how and why the equipment or service meets the needs of the individual will still be necessary;

5. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and,

6. The DHCS/IHO NE will adjudicate the TAR after all requested documentation has been received and reviewed, and a home visit has been conducted by appropriate program staff to determine the suitability of any requested equipment or service.

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

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

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

1. The recipient's place of residence changes; or

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

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

Under the HCBS IHO Waiver, the role of the HCBS Waiver Nurse Provider – Registered Nurse (RN) is to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Family Training
• Habilitation Services (HS)
• Private Duty Nursing (PDN)
• Respite Care
• Transitional Case Management (TCM)

The HCBS Waiver Nurse Provider – RN may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

Definitions:
a. “HCBS Waiver Nurse Provider – Registered Nurse (RN) ” means a RN, who provides HCBS

Waiver RN services, as defined in subsection A.2, below, and, in this capacity, is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

A HCBS Waiver RN may be a parent, stepparent, foster parent of a minor, a spouse, or legal guardian of the individual only under the following circumstances: there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained by only using this individual. DHCS/IHO may require additional documentation to support requests of this nature. Documentation required before DHCS/IHO can authorize such request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as a posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not hired or refused employment, if offered.

b. “HCBS Waiver RN services” means private duty nursing services, as described the in HCBS IHO Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an HCBS Waiver RN, as defined in subsection A.1, above, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

c. “Private duty nursing services” means services provided by a RN, which are more individual and continuous than those routinely available through a home health agency as in part-time or intermittent care on a limited basis.

d. “Medi-Cal Consultant” means either a RN or Physician, who is licensed to practice in the State and is an employee of DHCS/IHO.

e. “Education and/or training requirements” means any type of formal instruction related to the care needs of the individual for whom services are being requested. Examples of this could include certifications in a particular field, appropriate to the licensure status of the nurse; or continuing education units in the needs of the waiver participant, such as wound or pain management.

f. “Evaluation of theoretical knowledge and manual skills” means an assessment conducted by the RN of the licensed vocational nurse (LVN) in which the LVN is able to demonstrate competency in the provision of skilled nursing services. Examples of this could include having the LVN verbalize requirements for a certain procedure or process; having the RN review a certain task, demonstrate the task and then observing the LVN perform the tasks as prescribed on the POT. This evaluation would need to be documented and provided to DHCS/IHO as indicated.
Requirements of the HCBS Waiver RN:
1. Registered Nurse (RN) acting as the direct care provider:
a. The initial Treatment Authorization Request (TAR) shall be accompanied by all of the following documentation:
i. Current license to practice as a RN in the State of California.
ii. Current Basic Life Support (BLS) certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, which shall include at least one of the following:

A. A minimum of 1000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.

B. A minimum of 2000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT.

C. A minimum of 2000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) specified on the TAR and POT.

D. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS/IHO, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specified on the TAR and POT.

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

A. The appropriateness of the nursing assessment and interventions shall be determined by the Medi-Cal consultant based upon the waiver participant's medical condition and care need(s).

B. The POT shall be signed by the waiver participant, the RN, and the waiver participant's primary care physician, and shall contain the dates of service.

v. Signed release form from the waiver participant's primary care physician, which shall specify both of the following:
A. The primary care physician has knowledge that the RN providing care to the waiver participant is doing so without the affiliation of a home health agency or other licensed health care agency of record.

B. The primary care physician is willing to accept responsibility for the care rendered to the waiver participant.

vi. Written home safety evaluation, in a format acceptable to DHCS/IHO that demonstrates that the waiver participant's home environment supports the health and safety of the individual. This documentation shall include all of the following:
A. The area where the waiver participant will be cared for will accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies necessary to maintain the individual in the home in comfort and safety, and to facilitate the nursing care required.

B. Primary and back-up utility, communication, and fire safety systems and devices are installed and available in working order, which shall include grounded electrical outlets, smoke detectors, fire extinguisher, telephone, and notification of utility, emergency, and rescue systems that a person with special needs resides in the home.

C. The home complies with local fire, safety, building, and zoning ordinances, and the number of persons residing in the home does not exceed that permitted by such ordinances.

D. All medical equipment, supplies, primary and back-up systems, and other services and supports, identified in the POT, are in place and available in working order, or have been ordered and will be in place at the time the waiver participant is placed in the home.

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

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:
i. Evidence of renewal of BLS certification and RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/IHO, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.
iii. Written evidence, in a format acceptable to DHCS/IHO, of on-going contact with the waiver participant's primary care physician for the purpose of informing the primary care physician of the individual's progress, updating, or revising of the POT, and renewal of physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated primary

care physician orders. The updated POT shall be signed by the waiver participant's primary care physician, the RN, the waiver participant and will contain the dates of service.

2. RN case manager, waiver service coordinator, transitional case manager, and/or supervisor acting as the supervisor for a HCBS Waiver LVN:

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current license to practice as an RN in the State of California.
ii. Current BLS certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience providing case management, service coordination, and/or supervision or delegating nursing care tasks to an LVN or other subordinate staff.
iv. Written summary, in a format acceptable to DHCS/IHO, of nursing care tasks that have been delegated to the LVN.

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

i. Evidence of renewal of BLS certification and RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/IHO, of all case management, service coordination and/or supervisory activities which shall include all of the following:

A. Evaluation of the LVN's theoretical knowledge and manual skills needed to care for the individual for whom services have been requested.

B. The training provided to the LVN, as needed, to ensure appropriate care to the waiver participant for whom services have been requested.

C. Monitoring of the care rendered by the LVN, which shall include validation of post-training performance.

D. Any change in the nursing care tasks delegated to the LVN.

E. Evaluation of the case management and/or waiver coordination activities provided.
iii. Written evidence of ongoing contact with the waiver participant's primary care physician, as specified in section B., subsection 1(b)(iii), "requirements of the HCBS Waiver RN," above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the HCBS Waiver RN," above.

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Durable Medical Equipment (DME) Provider
Provider Qualifications
License *(specify):*

W&I 14043.15, 14043.2, 14043.25, 14043.26
Title 22, §51000.30(B)(3), §51000.55, §§51006(a)(1), (a)(2), (a)(3), (a)(5)
Certificate *(specify):*

Other Standard *(specify):*
Business license appropriate for the services purchased.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHCS, Food and Drug Division
Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual
Provider Type:
HCBS Benefit Provider - Marriage and Family Therapist
Provider Qualifications

License *(specify):*
BPC §§4980-4989
Title 16, §§1829-1848
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a MFT. Under the HCBS Waiver, the role of a MFT as a HCBS IHO Waiver Service Provider is to provide:

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Habilitation Services (HS)
• Transitional Case Management (TCM)

The MFT may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

A MFT who functions as a HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a MFT in the State of California.

2. Have work experience that includes, at least a minimum of 1000 hours experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The MFT must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management services consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO and within the MFT's scope of practice as follows:

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

b. Within the MFT's scope of practice, facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the MFT's scope of practice. The POT is updated and signed by the primary care physician no less frequently than once every six months
CBS Waiver Standards of Participation

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

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

License *(specify):*
BPC §§2909 et seq.
Title 16, §§1380 et seq.
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

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

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)

• Habilitation Services (HS)
• Transitional Case Management (TCM)

The Licensed Psychologist may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

A Licensed Psychologist who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California.

2. Have work experience that includes, at least a minimum of 1000 hours of experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The Licensed Psychologist must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management services within the scope of practice of a Licensed Psychologist consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO as follows:

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

b. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice. The POT must be updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Psychology

Frequency of Verification:

Biennially

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:
Home Health Agency (HHA)
Provider Qualifications
License *(specify):*
HHA Title 22, §74659 et seq.
Certificate *(specify):*
NA
Other Standard *(specify):*

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Non-Profit Agency
Provider Qualifications
License *(specify):*
Business license, appropriate for the services purchased
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

A Non-Profit Organization is a California service entity organized and operated under the United States Internal Revenue Code Section 501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBS IHO Waiver SOP and Medi-Cal Provider requirements may provide HCBS IHO Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified supervised unlicensed staff.

A Non-Profit Organization may provide the following HCBS IHO Waiver services:

• Case Management/Coordination (CM/C)
• Community Transition Services (CTS)
• Habilitation Services (HS)
• Transitional Case Management (TCM)
• Home Respite
• Waiver Personal Care Services (WPCS)

The Non-Profit Agency may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EEA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

Minimum qualifications for a Non-Profit Organization functioning as an HCBS IHO Waiver Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program possesses a Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community, or have al least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. The Non-Profit Organization shall maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. The Non-Profit Organization is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. The Non-Profit Organization is responsible for providing training and/or in-services to staff eligible to provide HCBS IHO Waiver services and at least annually reviews the HCBS IHO Waiver services requirements. Training of HCBS IHO Waiver service providers must be specific to the conditions and care of HCBS IHO Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBS IHO Waiver.

8. The Non-Profit Organization is responsible for the maintenance of waiver participant case documentation and financial records which support the claims for waiver services for a minimum period of three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), License Psychologist and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within his/her scope of licensure in the State of California. The Non-Profit Organization must maintain records of licensing for inspection and review by DHCS/IHO. The Non-Profit Organization must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM, TCM, CTS, HS, EAA, PERS, and/or MEOE to the elderly and/or persons with disabilities living in the community.

The Non-Profit Organization must maintain records and documentation of any and all requirements of the waiver/SOP for inspection and review by DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/IHO within 30 days of the change of licensure status. The Non-Profit Organization must also maintain

adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS/IHO.

10. Employs qualified professional providers to provide HCBS IHO CM/C, CTS, HS, EAA, PERS, TCM, and/or MEOE services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Must have earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM and/or MEOE services to the elderly and/or persons with disabilities living in the community.
The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation Services, which may include activities commonly described as peer mentoring, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher with 1000 hours experience in providing supervision to providers of services to the elderly and/or persons with disabilities living in the community, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have at least 1000 hours work experience in providing services to the elderly and/or persons with disabilities living in the community, or:

b. Have two years of experience in providing services to the elderly and/or persons with disabilities living in the community, through an organization or agency, or

c. Have one year experience as a Peer Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or in the community, through and organization or agency.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS/IHO.

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

a. Develop the IHO Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest, the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interests and medical care needs are addressed. The POT will identify all the choice and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and

b. Facilitate the process of collaboration and assessment with the participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician and/or the case manager/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and care needs of the participant. Assist the participant in accessing services that are beyond the licensed professional's scope of practice, credentialing, or experience. The POT

must be updated and signed by the participant and the primary care physician no less frequently than once every six months.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's Registry of Charitable Trusts

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - Licensed Clinical Social Worker (LCSW)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

NA

Other Standard *(specify):*

HCBS IHO Waiver Standards of Participation

A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the HCBS IHO Waiver, the role of a LCSW as a HCBS IHO Waiver Service Provider is to provide:

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Habilitation Services (HS)
• Transitional Case Management (TCM)

The LCSW may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

A LCSW who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a LCSW in the State of California.

2. Have work experience that includes, at least, a minimum of 1000 hours of providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The Licensed Clinical Social Worker must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management or transitional case management services within the scope of practice of a LCSW consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO, as follows:

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

b. Facilitate the process of assessing the beneficiary at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the beneficiary's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the beneficiary, as determined by the primary care physician. Assist the beneficiary in accessing medical care services that are beyond the LCSW's scope of practice. The POT is updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Behavioral Sciences

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Professional Corporation

Provider Qualifications

License *(specify):*

CC §13401(b)

Certificate *(specify):*

NA

Other Standard *(specify):*

HCBS IHO Waiver Standards of Participation

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

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Habilitation Services (HS)
• Transitional Case Management (TCM)

The Professional Corporation may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

1. The following are the licensed persons permitted to provide the above listed services as Professional Corporations to waiver participants under the terms of the HCBS IHO Waiver:

a. Licensed Psychologists (See Business and Professions Code section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;

b. Licensed Clinical Social Workers (LCSW) (See Business and Professions Code section 4996, et seq.); operating a Professional Corporation pursuant to Corporations Code section 13400, et seq., and

c. Marriage and Family Therapists (MFT) (See Business and Professions Code section 4980, et seq.) operating as a Professional Corporation pursuant to Corporations Code section 13400, et seq.

2. A Professional Corporation who functions as a HCBS IHO Waiver Service Provider shall:

a. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to Corporations Code section 13400, et seq., or if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation. Good standing of a domestic or foreign professional corporation must be maintained as long as the professional corporation is enrolled as an HCBS IHO Waiver provider. All Professional Corporations enrolling as HCBS IHO Waiver providers must provide a Certificate of Status of good standing to do business in the State of California (available from the Secretary of State's Office) upon enrollment and provide a current certificate of registration (pursuant to Corporations Code section 13401(b)) provided by the governmental agency regulating the profession. Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the certificate of registration. (Corporations Code section 13401(b)).

b. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.

c. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

i. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by DHCS/IHO. The professional corporation must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

ii. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 hours of experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

The Professional Corporation must maintain adequate documentation of the minimum hours of work

experience for each of its licensed persons for inspection and review by DHCS/IHO.

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

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

ii. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the licensed person's scope of practice. The POT must be updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

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:
None

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title

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 Waiver Personal Care Services (WPCS) providers enrolled to care for waiver participants. Training for family members and/or WPCS providers includes instruction about medical treatment, use of durable medical equipment, how to provide medical care services and specialized dietary plans for the participant in the absence of the paid care providers. All family training must be included in the participant's primary care physician signed POT.

WPCS providers 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 WPCS provider has the necessary skills, competencies and qualifications to provide those services. All WPCS training must be included in the participant's primary care physician signed POT.

Family/Caregiver Training services in the participant's home may be provided only by a Registered Nurse. To render Family/Caregiver Training the provider must document the training that is needed and the process to meet the need, and submit the documentation with a request for training to the DHCS RN. The DHCS RN will review the documentation and authorize the service when medically necessary to ensure the health and safety of the waiver participant. Upon completion of the training, the provider will submit documentation of the training results to the DHCS RN.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
None

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
Individual	HCBS Waiver Nurse Provider - Registered Nurse (RN)
Agency	Home Health Agency (HHA) - Registered Nurse (RN)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family/Caregiver Training

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

Under the HCBS IHO Waiver, the role of the HCBS Waiver Nurse Provider – Registered Nurse (RN) is to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Adaptations (EAA)
• Family Training
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Private Duty Nursing (PDN)
• Respite Care
• Transitional Case Management (TCM) 1.

Definitions:
a. "HCBS Waiver Nurse Provider – Registered Nurse (RN) " means a RN, who provides HCBS Waiver RN services, as defined in subsection A.2, below, and, in this capacity, is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

A HCBS Waiver RN may be a parent, stepparent, foster parent of a minor, a spouse, or legal guardian of the individual only under the following circumstances: there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained by only using this individual. DHCS/IHO may require additional documentation to support requests of this nature. Documentation required before DHCS/IHO can authorize such request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as a posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not hired or refused employment, if offered.

b. "HCBS Waiver RN services" means private duty nursing services, as described the in HCBS IHO Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an HCBS Waiver RN, as defined in subsection A.1, above, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

c. "Private duty nursing services" means services provided by a RN, which are more individual and continuous than those routinely available through a home health agency as in part-time or intermittent care on a limited basis.

d. “Medi-Cal Consultant” means either a RN or Physician, who is licensed to practice in the State and is an employee of DHCS/IHO.

e. “Education and/or training requirements” means any type of formal instruction related to the care needs of the individual for whom services are being requested. Examples of this could include certifications in a particular field, appropriate to the licensure status of the nurse; or continuing education units in the needs of the waiver participant, such as wound or pain management.

f. “Evaluation of theoretical knowledge and manual skills” means an assessment conducted by the RN of the licensed vocational nurse (LVN) in which the LVN is able to demonstrate competency in the provision of skilled nursing services. Examples of this could include having the LVN verbalize requirements for a certain procedure or process; having the RN review a certain task, demonstrate the task and then observing the LVN perform the tasks as prescribed on the POT. This evaluation would need to be documented and provided to DHCS/IHO as indicated.
Requirements of the HCBS Waiver RN:
1. Registered Nurse (RN) acting as the direct care provider:
a. The initial Treatment Authorization Request (TAR) shall be accompanied by all of the following documentation:
i. Current license to practice as a RN in the State of California.
ii. Current Basic Life Support (BLS) certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, which shall include at least one of the following:

A. A minimum of 1000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.

B. A minimum of 2000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT.

C. A minimum of 2000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) specified on the TAR and POT.

D. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS/IHO, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specified on the TAR and POT.

iv. A detailed POT that reflects an appropriate nursing assessment of the waiver participant, interventions, and the primary care physician’s orders.

A. The appropriateness of the nursing assessment and interventions shall be determined by the Medi-Cal consultant based upon the waiver participant’s medical condition and care need(s).

B. The POT shall be signed by the waiver participant, the RN, and the waiver participant’s primary care physician, and shall contain the dates of service.

v. Signed release form from the waiver participant’s primary care physician, which shall specify both of the following:
A. The primary care physician has knowledge that the RN providing care to the waiver participant is doing so without the affiliation of a home health agency or other licensed health care agency of record.

B. The primary care physician is willing to accept responsibility for the care rendered to the waiver participant.

vi. Written home safety evaluation, in a format acceptable to DHCS/IHO that demonstrates that the waiver participant’s home environment supports the health and safety of the individual. This documentation shall include all of the following:

A. The area where the waiver participant will be cared for will accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies necessary to maintain the individual in the home in comfort and safety, and to facilitate the nursing care required.

B. Primary and back-up utility, communication, and fire safety systems and devices are installed and available in working order, which shall include grounded electrical outlets, smoke detectors, fire extinguisher, telephone, and notification of utility, emergency, and rescue systems that a person with special needs resides in the home.

C. The home complies with local fire, safety, building, and zoning ordinances, and the number of persons residing in the home does not exceed that permitted by such ordinances.

D. All medical equipment, supplies, primary and back-up systems, and other services and supports, identified in the POT, are in place and available in working order, or have been ordered and will be in place at the time the waiver participant is placed in the home.

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

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:
i. Evidence of renewal of BLS certification and RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/IHO, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.
iii. Written evidence, in a format acceptable to DHCS/IHO, of on-going contact with the waiver participant's primary care physician for the purpose of informing the primary care physician of the individual's progress, updating, or revising of the POT, and renewal of physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated primary care physician orders. The updated POT shall be signed by the waiver participant's primary care physician, the RN, the waiver participant and will contain the dates of service.

2. RN case manager, waiver service coordinator, transitional case manager, and/or supervisor acting as the supervisor for a HCBS Waiver LVN:

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current license to practice as an RN in the State of California.
ii. Current BLS certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience providing case management, service coordination, and/or supervision or delegating nursing care tasks to an LVN or other subordinate staff.
iv. Written summary, in a format acceptable to DHCS/IHO, of nursing care tasks that have been delegated to the LVN.

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

i. Evidence of renewal of BLS certification and RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/IHO, of all case management, service coordination and/or supervisory activities which shall include all of the following:

A. Evaluation of the LVN's theoretical knowledge and manual skills needed to care for the individual for whom services have been requested.

B. The training provided to the LVN, as needed, to ensure appropriate care to the waiver participant

for whom services have been requested.

C. Monitoring of the care rendered by the LVN, which shall include validation of post-training performance.

D. Any change in the nursing care tasks delegated to the LVN.

E. Evaluation of the case management and/or waiver coordination activities provided.
iii. Written evidence of ongoing contact with the waiver participant's primary care physician, as specified in section B., subsection 1(b)(iii), "requirements of the HCBS Waiver RN," above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the HCBS 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: Family/Caregiver Training

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

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

Verification of Provider Qualifications

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Other Service

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

Service Title:

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

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

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

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

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

The minimum monthly claim for utility coverage reimbursement is $20.00, the maximum is $75.00.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

Provider Category:
Individual
Provider Type:
HCBS Benefit Provider - Licensed Clinical Social Worker (LCSW)
Provider Qualifications
License *(specify)*:
BPC §§4990-4998.7
Title 16, §§1870-1881
Certificate *(specify)*:
NA
Other Standard *(specify)*:
HCBS IHO Waiver Standards of Participation

A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the HCBS IHO Waiver, the role of a LCSW as a HCBS IHO Waiver Service Provider is to provide:

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Habilitation Services (HS)
• Transitional Case Management (TCM)

The LCSW may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

A LCSW who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a LCSW in the State of California.

2. Have work experience that includes, at least, a minimum of 1000 hours of providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The Licensed Clinical Social Worker must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management or transitional case management services within the scope of practice of a LCSW consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO, as follows:

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

b. Facilitate the process of assessing the beneficiary at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the beneficiary's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the beneficiary, as determined by the primary care physician. Assist the beneficiary in accessing medical care services that are beyond the LCSW's scope of practice. The POT is updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

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

HCBS IHO Waiver Standards of Participation

Under the HCBS IHO Waiver, the role of the HCBS Waiver Nurse Provider – Registered Nurse (RN) is to provide:

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Family Training
• Habilitation Services (HS)
• Private Duty Nursing (PDN)
• Respite Care
• Transitional Case Management (TCM)

The HCBS Waiver Nurse Provider – RN may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

Definitions:
a. "HCBS Waiver Nurse Provider – Registered Nurse (RN) " means a RN, who provides HCBS Waiver RN services, as defined in subsection A.2, below, and, in this capacity, is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

A HCBS Waiver RN may be a parent, stepparent, foster parent of a minor, a spouse, or legal guardian of the individual only under the following circumstances: there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained by only using this individual. DHCS/IHO may require additional documentation to support requests of this nature. Documentation required before DHCS/IHO can authorize such request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as a posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not hired or refused employment, if offered.

b. "HCBS Waiver RN services" means private duty nursing services, as described the in HCBS IHO Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an HCBS Waiver RN, as defined in subsection A.1, above, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

c. "Private duty nursing services" means services provided by a RN, which are more individual and continuous than those routinely available through a home health agency as in part-time or intermittent care on a limited basis.

d. "Medi-Cal Consultant" means either a RN or Physician, who is licensed to practice in the State and is an employee of DHCS/IHO.

e. "Education and/or training requirements" means any type of formal instruction related to the care needs of the individual for whom services are being requested. Examples of this could include certifications in a particular field, appropriate to the licensure status of the nurse; or continuing

education units in the needs of the waiver participant, such as wound or pain management.

f. "Evaluation of theoretical knowledge and manual skills" means an assessment conducted by the RN of the licensed vocational nurse (LVN) in which the LVN is able to demonstrate competency in the provision of skilled nursing services. Examples of this could include having the LVN verbalize requirements for a certain procedure or process; having the RN review a certain task, demonstrate the task and then observing the LVN perform the tasks as prescribed on the POT. This evaluation would need to be documented and provided to DHCS/IHO as indicated.
Requirements of the HCBS Waiver RN:
1. Registered Nurse (RN) acting as the direct care provider:
a. The initial Treatment Authorization Request (TAR) shall be accompanied by all of the following documentation:
i. Current license to practice as a RN in the State of California.
ii. Current Basic Life Support (BLS) certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, which shall include at least one of the following:

A. A minimum of 1000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.

B. A minimum of 2000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT.

C. A minimum of 2000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) specified on the TAR and POT.

D. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS/IHO, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specified on the TAR and POT.

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

A. The appropriateness of the nursing assessment and interventions shall be determined by the Medi-Cal consultant based upon the waiver participant's medical condition and care need(s).

B. The POT shall be signed by the waiver participant, the RN, and the waiver participant's primary care physician, and shall contain the dates of service.

v. Signed release form from the waiver participant's primary care physician, which shall specify both of the following:
A. The primary care physician has knowledge that the RN providing care to the waiver participant is doing so without the affiliation of a home health agency or other licensed health care agency of record.

B. The primary care physician is willing to accept responsibility for the care rendered to the waiver participant.

vi. Written home safety evaluation, in a format acceptable to DHCS/IHO that demonstrates that the waiver participant's home environment supports the health and safety of the individual. This documentation shall include all of the following:
A. The area where the waiver participant will be cared for will accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies necessary to maintain the individual in the home in comfort and safety, and to facilitate the nursing care required.

B. Primary and back-up utility, communication, and fire safety systems and devices are installed and available in working order, which shall include grounded electrical outlets, smoke detectors, fire

extinguisher, telephone, and notification of utility, emergency, and rescue systems that a person with special needs resides in the home.

C. The home complies with local fire, safety, building, and zoning ordinances, and the number of persons residing in the home does not exceed that permitted by such ordinances.

D. All medical equipment, supplies, primary and back-up systems, and other services and supports, identified in the POT, are in place and available in working order, or have been ordered and will be in place at the time the waiver participant is placed in the home.

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

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:
i. Evidence of renewal of BLS certification and RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/IHO, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.
iii. Written evidence, in a format acceptable to DHCS/IHO, of on-going contact with the waiver participant's primary care physician for the purpose of informing the primary care physician of the individual's progress, updating, or revising of the POT, and renewal of physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated primary care physician orders. The updated POT shall be signed by the waiver participant's primary care physician, the RN, the waiver participant and will contain the dates of service.

2. RN case manager, waiver service coordinator, transitional case manager, and/or supervisor acting as the supervisor for a HCBS Waiver LVN:

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current license to practice as an RN in the State of California.
ii. Current BLS certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience providing case management, service coordination, and/or supervision or delegating nursing care tasks to an LVN or other subordinate staff.
iv. Written summary, in a format acceptable to DHCS/IHO, of nursing care tasks that have been delegated to the LVN.

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

i. Evidence of renewal of BLS certification and RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/IHO, of all case management, service coordination and/or supervisory activities which shall include all of the following:

A. Evaluation of the LVN's theoretical knowledge and manual skills needed to care for the individual for whom services have been requested.

B. The training provided to the LVN, as needed, to ensure appropriate care to the waiver participant for whom services have been requested.

C. Monitoring of the care rendered by the LVN, which shall include validation of post-training performance.

D. Any change in the nursing care tasks delegated to the LVN.

E. Evaluation of the case management and/or waiver coordination activities provided.
iii. Written evidence of ongoing contact with the waiver participant's primary care physician, as specified in section B., subsection 1(b)(iii), "requirements of the HCBS Waiver RN," above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the HCBS 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:
Agency
Provider Type:
Home Health Agency (HHA) - Registered Nurse (RN)
Provider Qualifications

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

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

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

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

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

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

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Habilitation Services (HS)
• Transitional Case Management (TCM)

The Licensed Psychologist may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

A Licensed Psychologist who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California.

2. Have work experience that includes, at least a minimum of 1000 hours of experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The Licensed Psychologist must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management services within the scope of practice of a Licensed Psychologist consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO as follows:

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

b. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice. The POT must be updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

Provider Category:
Agency
Provider Type:
Professional Corporation
Provider Qualifications
License *(specify):*
CC §13401(b)
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

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

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Habilitation Services (HS)
• Transitional Case Management (TCM)

The Professional Corporation may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

1. The following are the licensed persons permitted to provide the above listed services as Professional Corporations to waiver participants under the terms of the HCBS IHO Waiver:

a. Licensed Psychologists (See Business and Professions Code section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;

b. Licensed Clinical Social Workers (LCSW) (See Business and Professions Code section 4996, et seq.); operating a Professional Corporation pursuant to Corporations Code section 13400, et seq., and

c. Marriage and Family Therapists (MFT) (See Business and Professions Code section 4980, et seq.) operating as a Professional Corporation pursuant to Corporations Code section 13400, et seq.

2. A Professional Corporation who functions as a HCBS IHO Waiver Service Provider shall:

a. Be currently and continuously incorporated in the State of California as a professional

corporation, pursuant to Corporations Code section 13400, et seq., or if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation. Good standing of a domestic or foreign professional corporation must be maintained as long as the professional corporation is enrolled as an HCBS IHO Waiver provider. All Professional Corporations enrolling as HCBS IHO Waiver providers must provide a Certificate of Status of good standing to do business in the State of California (available from the Secretary of State's Office) upon enrollment and provide a current certificate of registration (pursuant to Corporations Code section 13401(b)) provided by the governmental agency regulating the profession. Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the certificate of registration. (Corporations Code section 13401(b)).

b. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.

c. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

i. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by DHCS/IHO. The professional corporation must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

ii. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 hours of experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

The Professional Corporation must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS/IHO.

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

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

ii. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the licensed person's scope of practice. The POT must be updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

Provider Category:
Agency
Provider Type:
Non-Profit Agency
Provider Qualifications
License *(specify):*
Business license, appropriate for the services purchased
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

A Non-Profit Organization is a California service entity organized and operated under the United States Internal Revenue Code Section 501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBS IHO Waiver SOP and Medi-Cal Provider requirements may provide HCBS IHO Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified supervised unlicensed staff.

A Non-Profit Organization may provide the following HCBS IHO Waiver services:

• Case Management/Coordination (CM/C)
• Community Transition Services (CTS)
• Habilitation Services (HS)
• Transitional Case Management (TCM)
• Home Respite
• Waiver Personal Care Services (WPCS)

The Non-Profit Agency may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EEA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

Minimum qualifications for a Non-Profit Organization functioning as an HCBS IHO Waiver Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program possesses a Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community, or have al least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. The Non-Profit Organization shall maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. The Non-Profit Organization is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. The Non-Profit Organization is responsible for providing training and/or in-services to staff eligible to provide HCBS IHO Waiver services and at least annually reviews the HCBS IHO Waiver services requirements. Training of HCBS IHO Waiver service providers must be specific to the conditions and care of HCBS IHO Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBS IHO Waiver.

8. The Non-Profit Organization is responsible for the maintenance of waiver participant case documentation and financial records which support the claims for waiver services for a minimum period of three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), License Psychologist and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within his/her scope of licensure in the State of California. The Non-Profit Organization must maintain records of licensing for inspection and review by DHCS/IHO. The Non-Profit Organization must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM, TCM, CTS, HS, EAA, PERS, and/or MEOE to the elderly and/or persons with disabilities living in the community.

The Non-Profit Organization must maintain records and documentation of any and all requirements of the waiver/SOP for inspection and review by DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/IHO within 30 days of the change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS/IHO.

10. Employs qualified professional providers to provide HCBS IHO CM/C, CTS, HS, EAA, PERS, TCM, and/or MEOE services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Must have earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM and/or MEOE services to the elderly and/or persons with disabilities living in the community.
The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation Services, which may include activities commonly described as peer mentoring, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher with 1000 hours experience in providing supervision to providers of services to the elderly and/or persons with disabilities living in the community, the unlicensed providers must meet the following criteria:

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

least 1000 hours work experience in providing services to the elderly and/or persons with disabilities living in the community, or:

b. Have two years of experience in providing services to the elderly and/or persons with disabilities living in the community, through an organization or agency, or

c. Have one year experience as a Peer Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or in the community, through and organization or agency.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS/IHO.

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

a. Develop the IHO Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest, the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interests and medical care needs are addressed. The POT will identify all the choice and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and

b. Facilitate the process of collaboration and assessment with the participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician and/or the case manager/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and care needs of the participant. Assist the participant in accessing services that are beyond the licensed professional's scope of practice, credentialing, or experience. The POT must be updated and signed by the participant and the primary care physician no less frequently than once every six months.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's Registry of Charitable Trusts

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical Equipment Operating Expense

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):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a MFT. Under the HCBS Waiver, the role of a MFT as a HCBS IHO Waiver Service Provider is to provide:

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Habilitation Services (HS)
• Transitional Case Management (TCM)

The MFT may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

A MFT who functions as a HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a MFT in the State of California.

2. Have work experience that includes, at least a minimum of 1000 hours experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The MFT must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management services consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO and within the MFT's scope of practice as follows:

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

b. Within the MFT's scope of practice, facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the MFT's scope of practice. The POT is updated and signed by the primary care physician no less frequently than once every six months
CBS Waiver Standards of Participation

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 individuals at high risk of institutionalization to secure help in the event of an emergency. Authorization is limited to individuals who live alone, who are alone for significant parts of the day, have no regular caregiver for extended periods, and who would otherwise require routine supervision.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
None

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

- [x] **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	Durable Medical Equipment (DME) Provider
Individual	HCBS Waiver Nurse Provider - Registered Nurse (RN)
Agency	Non-Profit Agency
Agency	Professional Corporation
Individual	HCBS Benefit Provider - Marriage and Family Therapist (MFT)
Individual	HCBS Benefit Provider - Licensed Psychologist
Individual	HCBS Benefit Provider - Licensed Clinical Social Worker (LCSW)
Agency	Home Health 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:
Durable Medical Equipment (DME) Provider
Provider Qualifications
License *(specify)*:
W&I 14043.15, 14043.2, 14043.25, 14043.26
Title 22, §51000.30(B)(3), §51000.55, §§51006(a)(1), (a)(2), (a)(3), (a)(5)
Certificate *(specify)*:

Other Standard *(specify)*:
Business license appropriate for the services purchased.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHCS, Food and Drug Division
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 - Registered Nurse (RN)

Provider Qualifications

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

Certificate *(specify):*

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

Under the HCBS IHO Waiver, the role of the HCBS Waiver Nurse Provider – Registered Nurse (RN) is to provide:

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Family Training
• Habilitation Services (HS)
• Private Duty Nursing (PDN)
• Respite Care
• Transitional Case Management (TCM)

The HCBS Waiver Nurse Provider – RN may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

Definitions:
a. "HCBS Waiver Nurse Provider – Registered Nurse (RN) " means a RN, who provides HCBS Waiver RN services, as defined in subsection A.2, below, and, in this capacity, is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

A HCBS Waiver RN may be a parent, stepparent, foster parent of a minor, a spouse, or legal guardian of the individual only under the following circumstances: there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained by only using this individual. DHCS/IHO may require additional documentation to support requests of this nature. Documentation required before DHCS/IHO can authorize such request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as a posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not hired or refused employment, if offered.

b. "HCBS Waiver RN services" means private duty nursing services, as described the in HCBS IHO Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an HCBS Waiver RN, as defined in subsection A.1, above, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

c. "Private duty nursing services" means services provided by a RN, which are more individual and

continuous than those routinely available through a home health agency as in part-time or intermittent care on a limited basis.

d. “Medi-Cal Consultant” means either a RN or Physician, who is licensed to practice in the State and is an employee of DHCS/IHO.

e. “Education and/or training requirements” means any type of formal instruction related to the care needs of the individual for whom services are being requested. Examples of this could include certifications in a particular field, appropriate to the licensure status of the nurse; or continuing education units in the needs of the waiver participant, such as wound or pain management.

f. “Evaluation of theoretical knowledge and manual skills” means an assessment conducted by the RN of the licensed vocational nurse (LVN) in which the LVN is able to demonstrate competency in the provision of skilled nursing services. Examples of this could include having the LVN verbalize requirements for a certain procedure or process; having the RN review a certain task, demonstrate the task and then observing the LVN perform the tasks as prescribed on the POT. This evaluation would need to be documented and provided to DHCS/IHO as indicated.
Requirements of the HCBS Waiver RN:
1. Registered Nurse (RN) acting as the direct care provider:
a. The initial Treatment Authorization Request (TAR) shall be accompanied by all of the following documentation:
i. Current license to practice as a RN in the State of California.
ii. Current Basic Life Support (BLS) certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, which shall include at least one of the following:

A. A minimum of 1000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.

B. A minimum of 2000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT.

C. A minimum of 2000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) specified on the TAR and POT.

D. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS/IHO, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specified on the TAR and POT.

iv. A detailed POT that reflects an appropriate nursing assessment of the waiver participant, interventions, and the primary care physician’s orders.

A. The appropriateness of the nursing assessment and interventions shall be determined by the Medi-Cal consultant based upon the waiver participant’s medical condition and care need(s).

B. The POT shall be signed by the waiver participant, the RN, and the waiver participant’s primary care physician, and shall contain the dates of service.

v. Signed release form from the waiver participant’s primary care physician, which shall specify both of the following:
A. The primary care physician has knowledge that the RN providing care to the waiver participant is doing so without the affiliation of a home health agency or other licensed health care agency of record.

B. The primary care physician is willing to accept responsibility for the care rendered to the waiver participant.

vi. Written home safety evaluation, in a format acceptable to DHCS/IHO that demonstrates that the waiver participant's home environment supports the health and safety of the individual. This documentation shall include all of the following:
A. The area where the waiver participant will be cared for will accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies necessary to maintain the individual in the home in comfort and safety, and to facilitate the nursing care required.

B. Primary and back-up utility, communication, and fire safety systems and devices are installed and available in working order, which shall include grounded electrical outlets, smoke detectors, fire extinguisher, telephone, and notification of utility, emergency, and rescue systems that a person with special needs resides in the home.

C. The home complies with local fire, safety, building, and zoning ordinances, and the number of persons residing in the home does not exceed that permitted by such ordinances.

D. All medical equipment, supplies, primary and back-up systems, and other services and supports, identified in the POT, are in place and available in working order, or have been ordered and will be in place at the time the waiver participant is placed in the home.

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

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:
i. Evidence of renewal of BLS certification and RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/IHO, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.
iii. Written evidence, in a format acceptable to DHCS/IHO, of on-going contact with the waiver participant's primary care physician for the purpose of informing the primary care physician of the individual's progress, updating, or revising of the POT, and renewal of physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated primary care physician orders. The updated POT shall be signed by the waiver participant's primary care physician, the RN, the waiver participant and will contain the dates of service.

2. RN case manager, waiver service coordinator, transitional case manager, and/or supervisor acting as the supervisor for a HCBS Waiver LVN:

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current license to practice as an RN in the State of California.
ii. Current BLS certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience providing case management, service coordination, and/or supervision or delegating nursing care tasks to an LVN or other subordinate staff.
iv. Written summary, in a format acceptable to DHCS/IHO, of nursing care tasks that have been delegated to the LVN.

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

i. Evidence of renewal of BLS certification and RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/IHO, of all case management, service coordination and/or supervisory activities which shall include all of the following:

A. Evaluation of the LVN's theoretical knowledge and manual skills needed to care for the

individual for whom services have been requested.

B. The training provided to the LVN, as needed, to ensure appropriate care to the waiver participant for whom services have been requested.

C. Monitoring of the care rendered by the LVN, which shall include validation of post-training performance.

D. Any change in the nursing care tasks delegated to the LVN.

E. Evaluation of the case management and/or waiver coordination activities provided.
iii. Written evidence of ongoing contact with the waiver participant's primary care physician, as specified in section B., subsection 1(b)(iii), "requirements of the HCBS Waiver RN," above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the HCBS 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:
Agency
Provider Type:
Non-Profit Agency
Provider Qualifications

License *(specify):*
Business license, appropriate for the services purchased
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

A Non-Profit Organization is a California service entity organized and operated under the United States Internal Revenue Code Section 501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBS IHO Waiver SOP and Medi-Cal Provider requirements may provide HCBS IHO Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified supervised unlicensed staff.

A Non-Profit Organization may provide the following HCBS IHO Waiver services:

• Case Management/Coordination (CM/C)
• Community Transition Services (CTS)
• Habilitation Services (HS)
• Personal Emergency Response Systems (PERS)
• Transitional Case Management (TCM)
• Home Respite
• Waiver Personal Care Services (WPCS)

The Non-Profit Agency may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT,

obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EEA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

Minimum qualifications for a Non-Profit Organization functioning as an HCBS IHO Waiver Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program possesses a Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community, or have al least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. The Non-Profit Organization shall maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. The Non-Profit Organization is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. The Non-Profit Organization is responsible for providing training and/or in-services to staff eligible to provide HCBS IHO Waiver services and at least annually reviews the HCBS IHO Waiver services requirements. Training of HCBS IHO Waiver service providers must be specific to the conditions and care of HCBS IHO Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBS IHO Waiver.

8. The Non-Profit Organization is responsible for the maintenance of waiver participant case documentation and financial records which support the claims for waiver services for a minimum period of three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), License Psychologist and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within his/her scope of licensure in the State of California. The Non-Profit Organization must maintain records of licensing for inspection and review by DHCS/IHO. The Non-Profit Organization must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM, TCM, CTS, HS, EAA, PERS, and/or MEOE to the elderly and/or persons with disabilities living in the community.

The Non-Profit Organization must maintain records and documentation of any and all requirements of the waiver/SOP for inspection and review by DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/IHO within 30 days of the change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS/IHO.

10. Employs qualified professional providers to provide HCBS IHO CM/C, CTS, HS, EAA, PERS, TCM, and/or MEOE services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Must have earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM and/or MEOE services to the elderly and/or persons with disabilities living in the community.
The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation Services, which may include activities commonly described as peer mentoring, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher with 1000 hours experience in providing supervision to providers of services to the elderly and/or persons with disabilities living in the community, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have at least 1000 hours work experience in providing services to the elderly and/or persons with disabilities living in the community, or:

b. Have two years of experience in providing services to the elderly and/or persons with disabilities living in the community, through an organization or agency, or

c. Have one year experience as a Peer Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or in the community, through and organization or agency.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS/IHO.

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

a. Develop the IHO Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest, the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interests and medical care needs are addressed. The POT will identify all the choice and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and

b. Facilitate the process of collaboration and assessment with the participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician

and/or the case manager/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and care needs of the participant. Assist the participant in accessing services that are beyond the licensed professional's scope of practice, credentialing, or experience. The POT must be updated and signed by the participant and the primary care physician no less frequently than once every six months.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's Registry of Charitable Trusts

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response (PERS) - Installation and Testing

Provider Category:

Agency

Provider Type:

Professional Corporation

Provider Qualifications

License *(specify):*

CC §13401(b)

Certificate *(specify):*

NA

Other Standard *(specify):*

HCBS IHO Waiver Standards of Participation

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

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Habilitation Services (HS)
• Transitional Case Management (TCM)

The Professional Corporation may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

1. The following are the licensed persons permitted to provide the above listed services as Professional Corporations to waiver participants under the terms of the HCBS IHO Waiver:

a. Licensed Psychologists (See Business and Professions Code section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;

b. Licensed Clinical Social Workers (LCSW) (See Business and Professions Code section 4996, et seq.); operating a Professional Corporation pursuant to Corporations Code section 13400, et seq., and

c. Marriage and Family Therapists (MFT) (See Business and Professions Code section 4980, et seq.) operating as a Professional Corporation pursuant to Corporations Code section 13400, et seq.

2. A Professional Corporation who functions as a HCBS IHO Waiver Service Provider shall:

a. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to Corporations Code section 13400, et seq., or if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation. Good standing of a domestic or foreign professional corporation must be maintained as long as the professional corporation is enrolled as an HCBS IHO Waiver provider. All Professional Corporations enrolling as HCBS IHO Waiver providers must provide a Certificate of Status of good standing to do business in the State of California (available from the Secretary of State's Office) upon enrollment and provide a current certificate of registration (pursuant to Corporations Code section 13401(b)) provided by the governmental agency regulating the profession. Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the certificate of registration. (Corporations Code section 13401(b)).

b. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.

c. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

i. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by DHCS/IHO. The professional corporation must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

ii. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 hours of experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

The Professional Corporation must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS/IHO.

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

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

ii. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver

participant in accessing medical care services that are beyond the licensed person's scope of practice. The POT must be updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response (PERS) - Installation and Testing

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - Marriage and Family Therapist (MFT)

Provider Qualifications

License *(specify):*

BPC §§4980-4989
Title 16, §§1829-1848

Certificate *(specify):*

NA

Other Standard *(specify):*

HCBS IHO Waiver Standards of Participation

Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a MFT. Under the HCBS Waiver, the role of a MFT as a HCBS IHO Waiver Service Provider is to provide:

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Habilitation Services (HS)
• Transitional Case Management (TCM)

The MFT may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

A MFT who functions as a HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a MFT in the State of California.

2. Have work experience that includes, at least a minimum of 1000 hours experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The MFT must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management services consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO and within the MFT's scope of practice as follows:

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

b. Within the MFT's scope of practice, facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the MFT's scope of practice. The POT is updated and signed by the primary care physician no less frequently than once every six months

CBS Waiver Standards of Participation

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 Benefit Provider - Licensed Psychologist

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

NA

Other Standard *(specify):*

HCBS IHO Waiver Standards of Participation

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

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Habilitation Services (HS)
• Transitional Case Management (TCM)

The Licensed Psychologist may also facilitate the provision of the following services by

coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

A Licensed Psychologist who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California.

2. Have work experience that includes, at least a minimum of 1000 hours of experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The Licensed Psychologist must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management services within the scope of practice of a Licensed Psychologist consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO as follows:

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

b. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice. The POT must be updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

Entity Responsible for Verification:
California Board of 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 Clinical Social Worker (LCSW)
Provider Qualifications

License *(specify):*
BPC §§4990-4998.7
Title 16, §§1870-1881
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the HCBS IHO Waiver, the role of a LCSW as a HCBS IHO Waiver Service Provider is to provide:

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Habilitation Services (HS)
• Transitional Case Management (TCM)

The LCSW may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

A LCSW who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a LCSW in the State of California.

2. Have work experience that includes, at least, a minimum of 1000 hours of providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The Licensed Clinical Social Worker must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management or transitional case management services within the scope of practice of a LCSW consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO, as follows:

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

b. Facilitate the process of assessing the beneficiary at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the beneficiary's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the beneficiary, as determined by the primary care physician. Assist the beneficiary in accessing medical care services that are beyond the LCSW's scope of practice. The POT is updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Behavioral Sciences
Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response (PERS) - Installation and Testing

Provider Category:
Agency
Provider Type:
Home Health Agency (HHA)
Provider Qualifications
License *(specify):*
HHA Title 22, §74659 et seq.
Certificate *(specify):*
NA
Other Standard *(specify):*

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

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
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 Personal Emergency Response Systems (PERS) is a 24-hour emergency assistance electronic device that enables certain participants at high risk of institutionalization to secure help in an emotional, physical, or environmental emergency. PERS services are limited to participants who live alone, are alone for significant parts of the day, or have no regular caregiver for extended periods, and would otherwise require routine supervision.

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

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

PERS are individually designed to meet the needs and capabilities of the participant. The following services are allowed:
1. 24-hour answering/paging;
2. Beepers;
3. Med-alert bracelets;
4. Intercoms;
5. Life-lines;
6. Fire/safety devices, such as fire extinguishers and rope ladders;
7. Monitoring services;
8. Light fixture adaptations (blinking lights, etc.);
9. Telephone adaptive devices not available from the telephone company; and
10. Other electronic devices/services designed for emergency assistance.

All types of PERS, described above, shall meet applicable standards of manufacture, design, and installation. Repairs and maintenance of such equipment shall be performed by the manufacturer's authorized dealers whenever possible. Prior authorization for PERS services must be obtained by the waiver service provider from the DHCS/IHO NE.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
None

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**

☑ **Relative**
☑ **Legal Guardian**

Provider Specifications:

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

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):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

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

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Habilitation Services (HS)
• Transitional Case Management (TCM)

The Professional Corporation may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

1. The following are the licensed persons permitted to provide the above listed services as

Professional Corporations to waiver participants under the terms of the HCBS IHO Waiver:

a. Licensed Psychologists (See Business and Professions Code section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;

b. Licensed Clinical Social Workers (LCSW) (See Business and Professions Code section 4996, et seq.); operating a Professional Corporation pursuant to Corporations Code section 13400, et seq., and

c. Marriage and Family Therapists (MFT) (See Business and Professions Code section 4980, et seq.) operating as a Professional Corporation pursuant to Corporations Code section 13400, et seq.

2. A Professional Corporation who functions as a HCBS IHO Waiver Service Provider shall:

a. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to Corporations Code section 13400, et seq., or if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation. Good standing of a domestic or foreign professional corporation must be maintained as long as the professional corporation is enrolled as an HCBS IHO Waiver provider. All Professional Corporations enrolling as HCBS IHO Waiver providers must provide a Certificate of Status of good standing to do business in the State of California (available from the Secretary of State's Office) upon enrollment and provide a current certificate of registration (pursuant to Corporations Code section 13401(b)) provided by the governmental agency regulating the profession. Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the certificate of registration. (Corporations Code section 13401(b)).

b. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.

c. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

i. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by DHCS/IHO. The professional corporation must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

ii. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 hours of experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

The Professional Corporation must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS/IHO.

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

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

ii. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the licensed person's scope of

practice. The POT must be updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Agency

Provider Type:

Non-Profit Agency

Provider Qualifications

License *(specify):*

Business license, appropriate for the services purchased

Certificate *(specify):*

NA

Other Standard *(specify):*

HCBS IHO Waiver Standards of Participation

A Non-Profit Organization is a California service entity organized and operated under the United States Internal Revenue Code Section 501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBS IHO Waiver SOP and Medi-Cal Provider requirements may provide HCBS IHO Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified supervised unlicensed staff.

A Non-Profit Organization may provide the following HCBS IHO Waiver services:

• Case Management/Coordination (CM/C)
• Community Transition Services (CTS)
• Habilitation Services (HS)
• Personal Emergency Response Systems (PERS)
• Transitional Case Management (TCM)
• Home Respite
• Waiver Personal Care Services (WPCS)

The Non-Profit Agency may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EEA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) -

Minimum qualifications for a Non-Profit Organization functioning as an HCBS IHO Waiver Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program possesses a Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community, or have al least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. The Non-Profit Organization shall maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. The Non-Profit Organization is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. The Non-Profit Organization is responsible for providing training and/or in-services to staff eligible to provide HCBS IHO Waiver services and at least annually reviews the HCBS IHO Waiver services requirements. Training of HCBS IHO Waiver service providers must be specific to the conditions and care of HCBS IHO Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBS IHO Waiver.

8. The Non-Profit Organization is responsible for the maintenance of waiver participant case documentation and financial records which support the claims for waiver services for a minimum period of three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), License Psychologist and/or Marriage Family Therapist (MFT), who will render waiver services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within his/her scope of licensure in the State of California. The Non-Profit Organization must maintain records of licensing for inspection and review by DHCS/IHO. The Non-Profit Organization must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM, TCM, CTS, HS, EAA, PERS, and/or MEOE to the elderly and/or persons with disabilities living in the community.

The Non-Profit Organization must maintain records and documentation of any and all requirements of the waiver/SOP for inspection and review by DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/IHO within 30 days of the change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS/IHO.

10. Employs qualified professional providers to provide HCBS IHO CM/C, CTS, HS, EAA, PERS, TCM, and/or MEOE services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Must have earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an

accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM and/or MEOE services to the elderly and/or persons with disabilities living in the community. The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation Services, which may include activities commonly described as peer mentoring, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher with 1000 hours experience in providing supervision to providers of services to the elderly and/or persons with disabilities living in the community, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have at least 1000 hours work experience in providing services to the elderly and/or persons with disabilities living in the community, or:

b. Have two years of experience in providing services to the elderly and/or persons with disabilities living in the community, through an organization or agency, or

c. Have one year experience as a Peer Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or in the community, through and organization or agency.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS/IHO.

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

a. Develop the IHO Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest, the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interests and medical care needs are addressed. The POT will identify all the choice and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and

b. Facilitate the process of collaboration and assessment with the participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician and/or the case manager/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and care needs of the participant. Assist the participant in accessing services that are beyond the licensed professional's scope of practice, credentialing, or experience. The POT must be updated and signed by the participant and the primary care physician no less frequently than once every six months.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's Registry of Charitable Trusts

Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:
Individual
Provider Type:
HCBS Benefit Provider - Licensed Clinical Social Worker (LCSW)
Provider Qualifications
License *(specify):*
BPC §§4990-4998.7
Title 16, §§1870-1881
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the HCBS IHO Waiver, the role of a LCSW as a HCBS IHO Waiver Service Provider is to provide:

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Habilitation Services (HS)
• Transitional Case Management (TCM)

The LCSW may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

A LCSW who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a LCSW in the State of California.

2. Have work experience that includes, at least, a minimum of 1000 hours of providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The Licensed Clinical Social Worker must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management or transitional case management services within the scope of practice of a LCSW consistent with the primary care physician's orders and the POT as authorized by

DHCS/IHO, as follows:

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

b. Facilitate the process of assessing the beneficiary at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the beneficiary's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the beneficiary, as determined by the primary care physician. Assist the beneficiary in accessing medical care services that are beyond the LCSW's scope of practice. The POT is updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:
Individual

Provider Type:
HCBS Waiver Nurse Provider - Registered Nurse (RN)

Provider Qualifications

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

Certificate *(specify):*
RN

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

Under the HCBS IHO Waiver, the role of the HCBS Waiver Nurse Provider – Registered Nurse (RN) is to provide:

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Family Training
• Habilitation Services (HS)
• Private Duty Nursing (PDN)
• Respite Care
• Transitional Case Management (TCM)

The HCBS Waiver Nurse Provider – RN may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

Definitions:
a. "HCBS Waiver Nurse Provider – Registered Nurse (RN) " means a RN, who provides HCBS Waiver RN services, as defined in subsection A.2, below, and, in this capacity, is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

A HCBS Waiver RN may be a parent, stepparent, foster parent of a minor, a spouse, or legal guardian of the individual only under the following circumstances: there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained by only using this individual. DHCS/IHO may require additional documentation to support requests of this nature. Documentation required before DHCS/IHO can authorize such request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as a posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not hired or refused employment, if offered.

b. "HCBS Waiver RN services" means private duty nursing services, as described the in HCBS IHO Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an HCBS Waiver RN, as defined in subsection A.1, above, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

c. "Private duty nursing services" means services provided by a RN, which are more individual and continuous than those routinely available through a home health agency as in part-time or intermittent care on a limited basis.

d. "Medi-Cal Consultant" means either a RN or Physician, who is licensed to practice in the State and is an employee of DHCS/IHO.

e. "Education and/or training requirements" means any type of formal instruction related to the care needs of the individual for whom services are being requested. Examples of this could include certifications in a particular field, appropriate to the licensure status of the nurse; or continuing education units in the needs of the waiver participant, such as wound or pain management.

f. "Evaluation of theoretical knowledge and manual skills" means an assessment conducted by the RN of the licensed vocational nurse (LVN) in which the LVN is able to demonstrate competency in the provision of skilled nursing services. Examples of this could include having the LVN verbalize requirements for a certain procedure or process; having the RN review a certain task, demonstrate the task and then observing the LVN perform the tasks as prescribed on the POT. This evaluation would need to be documented and provided to DHCS/IHO as indicated.
Requirements of the HCBS Waiver RN:
1. Registered Nurse (RN) acting as the direct care provider:
a. The initial Treatment Authorization Request (TAR) shall be accompanied by all of the following documentation:
i. Current license to practice as a RN in the State of California.
ii. Current Basic Life Support (BLS) certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, which shall include at least one of the following:

A. A minimum of 1000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT. At least 500 of the 1000

hours shall be in a hospital medical-surgical unit.

B. A minimum of 2000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT.

C. A minimum of 2000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) specified on the TAR and POT.

D. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS/IHO, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specified on the TAR and POT.

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

A. The appropriateness of the nursing assessment and interventions shall be determined by the Medi-Cal consultant based upon the waiver participant's medical condition and care need(s).

B. The POT shall be signed by the waiver participant, the RN, and the waiver participant's primary care physician, and shall contain the dates of service.

v. Signed release form from the waiver participant's primary care physician, which shall specify both of the following:
A. The primary care physician has knowledge that the RN providing care to the waiver participant is doing so without the affiliation of a home health agency or other licensed health care agency of record.

B. The primary care physician is willing to accept responsibility for the care rendered to the waiver participant.

vi. Written home safety evaluation, in a format acceptable to DHCS/IHO that demonstrates that the waiver participant's home environment supports the health and safety of the individual. This documentation shall include all of the following:
A. The area where the waiver participant will be cared for will accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies necessary to maintain the individual in the home in comfort and safety, and to facilitate the nursing care required.

B. Primary and back-up utility, communication, and fire safety systems and devices are installed and available in working order, which shall include grounded electrical outlets, smoke detectors, fire extinguisher, telephone, and notification of utility, emergency, and rescue systems that a person with special needs resides in the home.

C. The home complies with local fire, safety, building, and zoning ordinances, and the number of persons residing in the home does not exceed that permitted by such ordinances.

D. All medical equipment, supplies, primary and back-up systems, and other services and supports, identified in the POT, are in place and available in working order, or have been ordered and will be in place at the time the waiver participant is placed in the home.

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

b. All subsequent reauthorization TARs shall be accompanied by all of the following

documentation, as specified:
i. Evidence of renewal of BLS certification and RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/IHO, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.
iii. Written evidence, in a format acceptable to DHCS/IHO, of on-going contact with the waiver participant's primary care physician for the purpose of informing the primary care physician of the individual's progress, updating, or revising of the POT, and renewal of physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated primary care physician orders. The updated POT shall be signed by the waiver participant's primary care physician, the RN, the waiver participant and will contain the dates of service.

2. RN case manager, waiver service coordinator, transitional case manager, and/or supervisor acting as the supervisor for a HCBS Waiver LVN:

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current license to practice as an RN in the State of California.
ii. Current BLS certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience providing case management, service coordination, and/or supervision or delegating nursing care tasks to an LVN or other subordinate staff.
iv. Written summary, in a format acceptable to DHCS/IHO, of nursing care tasks that have been delegated to the LVN.

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

i. Evidence of renewal of BLS certification and RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/IHO, of all case management, service coordination and/or supervisory activities which shall include all of the following:

A. Evaluation of the LVN's theoretical knowledge and manual skills needed to care for the individual for whom services have been requested.

B. The training provided to the LVN, as needed, to ensure appropriate care to the waiver participant for whom services have been requested.

C. Monitoring of the care rendered by the LVN, which shall include validation of post-training performance.

D. Any change in the nursing care tasks delegated to the LVN.

E. Evaluation of the case management and/or waiver coordination activities provided.
iii. Written evidence of ongoing contact with the waiver participant's primary care physician, as specified in section B., subsection 1(b)(iii), "requirements of the HCBS Waiver RN," above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the HCBS 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.
Title 16, §§1380 et seq.
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

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

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Habilitation Services (HS)
• Transitional Case Management (TCM)

The Licensed Psychologist may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

A Licensed Psychologist who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California.

2. Have work experience that includes, at least a minimum of 1000 hours of experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The Licensed Psychologist must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management services within the scope of practice of a Licensed Psychologist consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO as follows:

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

b. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's

status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice. The POT must be updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Psychology

Frequency of Verification:

Biennially

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Agency

Provider Type:

Durable Medical Equipment (DME) Provider

Provider Qualifications

License *(specify)*:

W&I 14043.15, 14043.2, 14043.25, 14043.26
Title 22, §51000.30(B)(3), §51000.55, §§51006(a)(1), (a)(2), (a)(3), (a)(5)

Certificate *(specify)*:

Other Standard *(specify)*:

Business license appropriate for the services purchased.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHCS, Food and Drug Division

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Agency

Provider Type:

Home Health Agency (HHA)

Provider Qualifications

License *(specify)*:

HHA Title 22, §74659 et seq.

Certificate *(specify)*:

NA

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - Marriage and Family Therapist (MFT)

Provider Qualifications

License *(specify):*

BPC §§4980-4989

Title 16, §§1829-1848

Certificate *(specify):*

NA

Other Standard *(specify):*

HCBS IHO Waiver Standards of Participation

Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a MFT. Under the HCBS Waiver, the role of a MFT as a HCBS IHO Waiver Service Provider is to provide:

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Habilitation Services (HS)
• Transitional Case Management (TCM)

The MFT may also facilitate the provision of the following services by coordinating the necessary medical documentation, obtaining the required evaluations, updating the POT, obtaining the necessary preauthorization for services by submitting a Treatment Authorization Request (TAR) to the appropriate IHO regional office and acting as a conduit between the actual qualified provider of the service and the Medi-Cal fiscal intermediary for billing and payment for services rendered.

• Environmental Accessibility Adaptations (EAA)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response (PERS) - Installation and Testing
• Personal Emergency Response System (PERS) - Monthly

A MFT who functions as a HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a MFT in the State of California.

2. Have work experience that includes, at least a minimum of 1000 hours experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The MFT must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management services consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO and within the MFT's scope of practice as follows:

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

b. Within the MFT's scope of practice, facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the MFT's scope of practice. The POT is updated and signed by the primary care physician no less frequently than once every six months
CBS Waiver Standards of Participation

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:
Private Duty Nursing - Including 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):*
Private Duty Nursing services are individual and continuous care (in contrast to part-time or intermittent care) provided by a licensed nurse or a certified home health aide under a home health agency within the scope of state law. Services are provided to a waiver participant in his/her home or home-like environment.

Shared PDN services are provided to two participants who live at the same residence. Shared PDN services are provided only on request and agreement of the involved participants and/or his/her authorized representative(s).

A HCBS RN provides supervision and monitoring of PDN or Shared PDN services if provided by an HCBS LVN.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
DHCS/IHO will not authorize direct care services or any combination of direct care and protective supervision services exceeding 24 hours of care per day under this waiver regardless of the funding source. Direct care services include State Plan services, such as personal care services, adult or pediatric day health care, In-Home Supportive Services (IHSS) Plus Waiver services, PDN, shared PDN, and/or direct care authorized by the participant's private insurance. Direct care is hands on care to support the care needs of the waiver participant. Protective supervision is observing the participant's behavior in order to safeguard the participant against injury, hazard, or accident.

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	Home Health Agency (HHA) - Licensed Vocational Nurse (LVN)
Individual	HCBS Waiver Nurse Provide - Registered Nurse (RN)
Agency	Home Health Agency (HHA) - Registered Nurse (RN)
Agency	Home Health Agency (HHA) - Certified Home Health Aide (CHHA)
Individual	HCBS Waiver Nurse Provider - Licensed Vocational Nurse (LVN)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing - Including Shared Services

Provider Category:
Agency
Provider Type:
Home Health Agency (HHA) - Licensed Vocational Nurse (LVN)
Provider Qualifications

License *(specify):*
HHA Title 22, §§74659-74689
LVN BPC §§2859-2873.7
Title 22, §51069;
Certificate *(specify):*
NA
Other Standard *(specify):*

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing - Including Shared Services

Provider Category:
Individual
Provider Type:
HCBS Waiver Nurse Provide - Registered Nurse (RN)
Provider Qualifications
License *(specify):*
BPC §§2725 et seq.
Title 22, §51067;
Title 16, §1409-1419.4
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

Under the HCBS IHO Waiver, the role of the HCBS Waiver Nurse Provider – Registered Nurse (RN) is to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Adaptations (EAA)
• Family Training
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Private Duty Nursing (PDN)
• Respite Care
• Transitional Case Management (TCM) 1.

Definitions:
a. "HCBS Waiver Nurse Provider – Registered Nurse (RN) " means a RN, who provides HCBS Waiver RN services, as defined in subsection A.2, below, and, in this capacity, is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

A HCBS Waiver RN may be a parent, stepparent, foster parent of a minor, a spouse, or legal guardian of the individual only under the following circumstances: there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained by only using this individual. DHCS/IHO may require additional

documentation to support requests of this nature. Documentation required before DHCS/IHO can authorize such request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as a posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not hired or refused employment, if offered.

b. "HCBS Waiver RN services" means private duty nursing services, as described the in HCBS IHO Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an HCBS Waiver RN, as defined in subsection A.1, above, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

c. "Private duty nursing services" means services provided by a RN, which are more individual and continuous than those routinely available through a home health agency as in part-time or intermittent care on a limited basis.

d. "Medi-Cal Consultant" means either a RN or Physician, who is licensed to practice in the State and is an employee of DHCS/IHO.

e. "Education and/or training requirements" means any type of formal instruction related to the care needs of the individual for whom services are being requested. Examples of this could include certifications in a particular field, appropriate to the licensure status of the nurse; or continuing education units in the needs of the waiver participant, such as wound or pain management.

f. "Evaluation of theoretical knowledge and manual skills" means an assessment conducted by the RN of the licensed vocational nurse (LVN) in which the LVN is able to demonstrate competency in the provision of skilled nursing services. Examples of this could include having the LVN verbalize requirements for a certain procedure or process; having the RN review a certain task, demonstrate the task and then observing the LVN perform the tasks as prescribed on the POT. This evaluation would need to be documented and provided to DHCS/IHO as indicated.
Requirements of the HCBS Waiver RN:
1. Registered Nurse (RN) acting as the direct care provider:
a. The initial Treatment Authorization Request (TAR) shall be accompanied by all of the following documentation:
i. Current license to practice as a RN in the State of California.
ii. Current Basic Life Support (BLS) certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, which shall include at least one of the following:

A. A minimum of 1000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.

B. A minimum of 2000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT.

C. A minimum of 2000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) specified on the TAR and POT.

D. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS/IHO, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specified on the TAR and POT.

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

A. The appropriateness of the nursing assessment and interventions shall be determined by the Medi-Cal consultant based upon the waiver participant's medical condition and care need(s).

B. The POT shall be signed by the waiver participant, the RN, and the waiver participant's primary care physician, and shall contain the dates of service.

v. Signed release form from the waiver participant's primary care physician, which shall specify both of the following:
A. The primary care physician has knowledge that the RN providing care to the waiver participant is doing so without the affiliation of a home health agency or other licensed health care agency of record.

B. The primary care physician is willing to accept responsibility for the care rendered to the waiver participant.

vi. Written home safety evaluation, in a format acceptable to DHCS/IHO that demonstrates that the waiver participant's home environment supports the health and safety of the individual. This documentation shall include all of the following:
A. The area where the waiver participant will be cared for will accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies necessary to maintain the individual in the home in comfort and safety, and to facilitate the nursing care required.

B. Primary and back-up utility, communication, and fire safety systems and devices are installed and available in working order, which shall include grounded electrical outlets, smoke detectors, fire extinguisher, telephone, and notification of utility, emergency, and rescue systems that a person with special needs resides in the home.

C. The home complies with local fire, safety, building, and zoning ordinances, and the number of persons residing in the home does not exceed that permitted by such ordinances.

D. All medical equipment, supplies, primary and back-up systems, and other services and supports, identified in the POT, are in place and available in working order, or have been ordered and will be in place at the time the waiver participant is placed in the home.

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

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:
i. Evidence of renewal of BLS certification and RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/IHO, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.
iii. Written evidence, in a format acceptable to DHCS/IHO, of on-going contact with the waiver participant's primary care physician for the purpose of informing the primary care physician of the individual's progress, updating, or revising of the POT, and renewal of physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated primary care physician orders. The updated POT shall be signed by the waiver participant's primary care physician, the RN, the waiver participant and will contain the dates of service.

2. RN case manager, waiver service coordinator, transitional case manager, and/or supervisor acting as the supervisor for a HCBS Waiver LVN:

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current license to practice as an RN in the State of California.

ii. Current BLS certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience providing case management, service coordination, and/or supervision or delegating nursing care tasks to an LVN or other subordinate staff.
iv. Written summary, in a format acceptable to DHCS/IHO, of nursing care tasks that have been delegated to the LVN.

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

i. Evidence of renewal of BLS certification and RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/IHO, of all case management, service coordination and/or supervisory activities which shall include all of the following:

A. Evaluation of the LVN's theoretical knowledge and manual skills needed to care for the individual for whom services have been requested.

B. The training provided to the LVN, as needed, to ensure appropriate care to the waiver participant for whom services have been requested.

C. Monitoring of the care rendered by the LVN, which shall include validation of post-training performance.

D. Any change in the nursing care tasks delegated to the LVN.

E. Evaluation of the case management and/or waiver coordination activities provided.
iii. Written evidence of ongoing contact with the waiver participant's primary care physician, as specified in section B., subsection 1(b)(iii), "requirements of the HCBS Waiver RN," above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the HCBS Waiver RN," above.

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing - Including Shared Services

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

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

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing - Including Shared Services

Provider Category:
Agency
Provider Type:
Home Health Agency (HHA) - Certified Home Health Aide (CHHA)
Provider Qualifications
License *(specify):*
HHA Title 22, §§74659 et seq.
Certificate *(specify):*
CHHA BPC §§1736.1-1736.6
Other Standard *(specify):*

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing - Including Shared Services

Provider Category:
Individual
Provider Type:
HCBS Waiver Nurse Provider - Licensed Vocational Nurse (LVN)
Provider Qualifications
License *(specify):*
BPC §§2859-2873.7
Title 22, §51069
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

Under the HCBS IHO Waiver, the role of the HCBS Waiver Nurse Provider – Licensed Vocation Nurse (LVN) is to provide:
• Private Duty Nursing (PDN)
• Respite Care

1. Definitions:

a. "HCBS Waiver Nurse Provider – Licensed Vocational Nurse (LVN)" means a LVN who provides HCBS Waiver LVN services, as defined in subsection A.2, below, and, in this capacity, is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

A HCBS Waiver LVN may be a parent, stepparent, foster parent of a minor, a spouse, or legal guardian of the individual only under the following circumstances: there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained by only using this individual. DHCS/IHO may require additional documentation to support requests of this nature. Documentation required before DHCS/IHO can authorize such request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not hired or refused employment, if offered.

b. "HCBS Waiver LVN services" means private duty nursing services, as described the in HCBS IHO Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an HCBS Waiver LVN, as defined in subsection A.1, above, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

c. "Private duty nursing services" means services provided by a LVN, which are more individual and continuous than those routinely available through a home health agency as in part-time or intermittent care on a limited basis.

d. "Education and/or training requirements" means any type of formal instruction related to the care needs of the individual for whom services are being requested. Examples of this could include certifications in a particular field, appropriate to the licensure status of the nurse; or continuing education units in the needs of the waiver participant such as wound or pain management.

Requirements of the HCBS Waiver LVN:

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

a. Current license to practice as an LVN in the State of California.

b. Current BLS certification.

c. Name and RN license number of the individual who will be providing ongoing supervision. Such supervision shall be required at a minimum of two hours per calendar month.

d. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, as specified in section B, subsection 1(a)(iii), "requirements of the HCBS Waiver LVN", above.

e. Copy of the detailed POT that reflects the RN nursing assessment of the waiver participant and the primary care physician's orders. The POT shall be signed by the supervising RN, the waiver participant's primary care physician, the waiver participant, and the LVN.

f. Written home safety evaluation, in a format acceptable to DHCS/IHO, as specified in section B, subsection 1(a)(vi), "requirements of the HCBS Waiver LVN," above.

g. Medical information, as specified in section B., subsection 1(a)(vii), "requirements of the "HCBS Waiver LVN provider," above.

2. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

a. Evidence of renewal of BLS certification and LVN licensure prior to expiration.

b. Written evidence, in a format acceptable to DHCS/IHO, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.

c. Copy of the updated POT that reflects the ongoing RN nursing assessment and updated primary care physician's orders. The POT shall be signed by the supervising RN, the waiver participant's primary care physician, the waiver participant, and the LVN, and shall contain the dates of service.

3. A TAR or similar request must be approved in advance by DHCS/IHO and shall be required for each HCBS Waiver LVN service request. Initial authorization shall be granted for a period of up to 90 days, and reauthorization shall be granted for periods of up to 180 days.

4. The HCBS Waiver LVN shall agree to notify DHCS/IHO and the waiver participant or his/her legal guardian, in writing, at least thirty (30) days prior to the effective date of termination when the HCBS Waiver LVN intends to terminate HCBS, LVN services. This time period may be less than thirty (30) days if there are immediate issues of health and safety for either the nurse or the waiver participant, as determined by the DHCS/IHO.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Vocational Nursing and Psychiatric Technicians

Frequency of Verification:

Biennially

Appendix C: Participant Services

C-1/C-3: 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 a home and community-based setting. TCM providers will have direct contact with the participant, his/her circle of support and the participant's primary care physician to obtain information that will allow the TCM provider to coordinate services such as housing, equipment, supplies, or transportation that may be necessary to leave a health care facility. TCM services may be provided up to 180 days prior to discharge from a health care facility. All TCM services provided will be billed against the waiver on the date of waiver enrollment. If the participant should decease before discharge, the TCM services provided may be claimed as an administrative expense under the State Plan.

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

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

The use of this service will necessarily result in a reduction in other waiver services the participant may receive during the same year that Transitional Case Management services are authorized. The participant waiver costs must be cost neutral to the inpatient alternative. The participant should understand the possible fiscal impact of receiving this service at the time of request for Transitional Case Management services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
TCM services may be provided up to 180 days prior to discharge from health care facility. These services will be provided before the individual's enrollment in the waiver.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transitional Case Management

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

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transitional Case Management

Provider Category:
Individual
Provider Type:
HCBS Benefit Provider - Marriage and Family Therapist (MFT)
Provider Qualifications
License *(specify):*
BPC §§4980– 4989
Title 16, §§1829-1848
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a MFT. Under the HCBS Waiver, the role of a MFT as a HCBS IHO Waiver Service Provider is to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Accessibility Adaptations (EAA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Transitional Case Management (TCM)

A MFT who functions as a HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a MFT in the State of California.

2. Have work experience that includes, at least a minimum of 1000 hours experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The MFT must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management services consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO and within the MFT's scope of practice as follows:

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

b. Within the MFT's scope of practice, facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the MFT's scope of practice. The POT is updated and signed by the primary care physician no less frequently than once every six months

CBS Waiver Standards of Participation

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Behavioral Sciences

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transitional Case Management

Provider Category:

Individual

Provider Type:

HCBS Waiver Nurse Provider - Registered Nurse (RN)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

NA

Other Standard *(specify):*

HCBS IHO Waiver Standards of Participation

Under the HCBS IHO Waiver, the role of the HCBS Waiver Nurse Provider – Registered Nurse (RN) is to provide:

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Adaptations (EAA)
• Family Training
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Private Duty Nursing (PDN)
• Respite Care
• Transitional Case Management (TCM) 1.

Definitions:
a. "HCBS Waiver Nurse Provider – Registered Nurse (RN) " means a RN, who provides HCBS Waiver RN services, as defined in subsection A.2, below, and, in this capacity, is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization.

A HCBS Waiver RN may be a parent, stepparent, foster parent of a minor, a spouse, or legal guardian of the individual only under the following circumstances: there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained by only using this individual. DHCS/IHO may require additional documentation to support requests of this nature. Documentation required before DHCS/IHO can authorize such request, is a written explanation of the attempts made to enlist and retain an HCBS Waiver Nurse Provider, such as a posting classified advertisements for Individual Nurse Providers in the community and/or contacts with Home Health Agencies, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not hired or refused employment, if offered.

b. "HCBS Waiver RN services" means private duty nursing services, as described the in HCBS IHO Waiver in Appendix C (Participant Services), provided to a waiver participant in his/her home or place of residence by an HCBS Waiver RN, as defined in subsection A.1, above, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

c. "Private duty nursing services" means services provided by a RN, which are more individual and continuous than those routinely available through a home health agency as in part-time or intermittent care on a limited basis.

d. "Medi-Cal Consultant" means either a RN or Physician, who is licensed to practice in the State and is an employee of DHCS/IHO.

e. "Education and/or training requirements" means any type of formal instruction related to the care needs of the individual for whom services are being requested. Examples of this could include certifications in a particular field, appropriate to the licensure status of the nurse; or continuing education units in the needs of the waiver participant, such as wound or pain management.

f. "Evaluation of theoretical knowledge and manual skills" means an assessment conducted by the RN of the licensed vocational nurse (LVN) in which the LVN is able to demonstrate competency in the provision of skilled nursing services. Examples of this could include having the LVN verbalize requirements for a certain procedure or process; having the RN review a certain task, demonstrate the task and then observing the LVN perform the tasks as prescribed on the POT. This evaluation would need to be documented and provided to DHCS/IHO as indicated.
Requirements of the HCBS Waiver RN:
1. Registered Nurse (RN) acting as the direct care provider:
a. The initial Treatment Authorization Request (TAR) shall be accompanied by all of the following documentation:
i. Current license to practice as a RN in the State of California.
ii. Current Basic Life Support (BLS) certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience, which shall

include at least one of the following:

A. A minimum of 1000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.

B. A minimum of 2000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT.

C. A minimum of 2000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) specified on the TAR and POT.

D. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHCS/IHO, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specified on the TAR and POT.

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

A. The appropriateness of the nursing assessment and interventions shall be determined by the Medi-Cal consultant based upon the waiver participant's medical condition and care need(s).

B. The POT shall be signed by the waiver participant, the RN, and the waiver participant's primary care physician, and shall contain the dates of service.

v. Signed release form from the waiver participant's primary care physician, which shall specify both of the following:
A. The primary care physician has knowledge that the RN providing care to the waiver participant is doing so without the affiliation of a home health agency or other licensed health care agency of record.

B. The primary care physician is willing to accept responsibility for the care rendered to the waiver participant.

vi. Written home safety evaluation, in a format acceptable to DHCS/IHO that demonstrates that the waiver participant's home environment supports the health and safety of the individual. This documentation shall include all of the following:
A. The area where the waiver participant will be cared for will accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies necessary to maintain the individual in the home in comfort and safety, and to facilitate the nursing care required.

B. Primary and back-up utility, communication, and fire safety systems and devices are installed and available in working order, which shall include grounded electrical outlets, smoke detectors, fire extinguisher, telephone, and notification of utility, emergency, and rescue systems that a person with special needs resides in the home.

C. The home complies with local fire, safety, building, and zoning ordinances, and the number of persons residing in the home does not exceed that permitted by such ordinances.

D. All medical equipment, supplies, primary and back-up systems, and other services and supports, identified in the POT, are in place and available in working order, or have been ordered and will be in place at the time the waiver participant is placed in the home.

vii. Medical information that supports the request for the services. May include a history and physical completed by the waiver participant's primary care physician within the previous three months for an individual under the age of 21 and within the previous six months for an individual 21 years of age or older. If the last history and physical was completed outside of the respective timeframes, the history and physical shall be accompanied by documentation of the most recent

office visit, which shall contain a detailed summary of medical findings that includes a body systems examination.

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:
i. Evidence of renewal of BLS certification and RN licensure prior to expiration.
ii. Written evidence, in a format acceptable to DHCS/IHO, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.
iii. Written evidence, in a format acceptable to DHCS/IHO, of on-going contact with the waiver participant's primary care physician for the purpose of informing the primary care physician of the individual's progress, updating, or revising of the POT, and renewal of physician orders.
iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated primary care physician orders. The updated POT shall be signed by the waiver participant's primary care physician, the RN, the waiver participant and will contain the dates of service.

2. RN case manager, waiver service coordinator, transitional case manager, and/or supervisor acting as the supervisor for a HCBS Waiver LVN:

a. The initial TAR shall be accompanied by all of the following documentation:
i. Current license to practice as an RN in the State of California.
ii. Current BLS certification.
iii. Written evidence, in a format acceptable to DHCS/IHO, of training or experience providing case management, service coordination, and/or supervision or delegating nursing care tasks to an LVN or other subordinate staff.
iv. Written summary, in a format acceptable to DHCS/IHO, of nursing care tasks that have been delegated to the LVN.

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

i. Evidence of renewal of BLS certification and RN licensing prior to expiration.
ii. Written summary, in a format acceptable to DHCS/IHO, of all case management, service coordination and/or supervisory activities which shall include all of the following:

A. Evaluation of the LVN's theoretical knowledge and manual skills needed to care for the individual for whom services have been requested.

B. The training provided to the LVN, as needed, to ensure appropriate care to the waiver participant for whom services have been requested.

C. Monitoring of the care rendered by the LVN, which shall include validation of post-training performance.

D. Any change in the nursing care tasks delegated to the LVN.

E. Evaluation of the case management and/or waiver coordination activities provided.
iii. Written evidence of ongoing contact with the waiver participant's primary care physician, as specified in section B., subsection 1(b)(iii), "requirements of the HCBS Waiver RN," above.
iv. An updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the HCBS 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:
Professional Corporation
Provider Qualifications
License *(specify):*
CC §13401(b)
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

A Professional Corporation is a provider that employs individuals who provide services authorized under the HCBS IHO Waiver and is enrolled as an HCBS IHO Waiver Professional Corporation provider in the HCBS IHO Waiver, and meets and maintains the SOP minimal qualifications for a Professional Corporation. Under the HCBS IHO Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Accessibility Adaptations (EAA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Transitional Case Management (TCM)

1. The following are the licensed persons permitted to provide the above listed services as Professional Corporations to waiver participants under the terms of the HCBS IHO Waiver:

a. Licensed Psychologists (See Business and Professions Code section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;

b. Licensed Clinical Social Workers (LCSW) (See Business and Professions Code section 4996, et seq.); operating a Professional Corporation pursuant to Corporations Code section 13400, et seq., and

c. Marriage and Family Therapists (MFT) (See Business and Professions Code section 4980, et seq.) operating as a Professional Corporation pursuant to Corporations Code section 13400, et seq.

2. A Professional Corporation who functions as a HCBS IHO Waiver Service Provider shall:

a. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to Corporations Code section 13400, et seq., or if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation. Good standing of a domestic or foreign professional corporation must be maintained as long as the professional corporation is enrolled as an HCBS IHO Waiver provider. All Professional Corporations enrolling as HCBS IHO Waiver providers must provide a Certificate of Status of good standing to do business in the State of California (available from the Secretary of State's Office) upon enrollment and provide a current certificate of registration (pursuant to Corporations Code section 13401(b)) provided by the governmental agency regulating the profession. Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the certificate of registration. (Corporations Code section 13401(b)).

b. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.

c. Employ licensed persons as specified above who will render waiver services to waiver participants as requested and authorized and who meet the following criteria:

i. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by DHCS/IHO. The professional corporation must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

ii. Employ licensed persons who have documented work experience that includes, as least, a minimum of 1000 hours of experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

The Professional Corporation must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS/IHO.

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

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

ii. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the licensed person's scope of practice. The POT must be updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH Licensing and Certification

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transitional Case Management

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - Licensed Clinical Social Worker (LCSW)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

NA

Other Standard *(specify):*

HCBS IHO Waiver Standards of Participation

A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the HCBS IHO Waiver and who meets and maintains the SOP minimal qualifications for a LCSW. Under the HCBS IHO Waiver, the role of a LCSW as a HCBS IHO Waiver Service Provider is to provide:
• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Accessibility Adaptations (EAA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Transitional Case Management (TCM)

A LCSW who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a LCSW in the State of California.

2. Have work experience that includes, at least, a minimum of 1000 hours of providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The Licensed Clinical Social Worker must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management or transitional case management services within the scope of practice of a LCSW consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO, as follows:

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

b. Facilitate the process of assessing the beneficiary at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the beneficiary's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the beneficiary, as determined by the primary care physician. Assist the beneficiary in accessing medical care services that are beyond the LCSW's scope of practice. The POT is updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transitional Case Management

Provider Category:
Agency
Provider Type:
Non-Profit Agency
Provider Qualifications
License *(specify):*

Business license, appropriate for the services purchased
Certificate *(specify):*
NA
Other Standard *(specify):*
HCBS IHO Waiver Standards of Participation

A Non-Profit Organization is a California service entity organized and operated under the United States Internal Revenue Code Section 501(c)(3), and provides services to the elderly and persons with disabilities. A Non-Profit Organization meeting the HCBS IHO Waiver SOP and Medi-Cal Provider requirements may provide HCBS IHO Waiver services utilizing licensed professionals, qualified professional staff, and/or qualified supervised unlicensed staff.

A Non-Profit Organization may provide the following HCBS IHO Waiver services:
• Case Management/Coordination (CM/C)
• Community Transition Services (CTS)
• Environmental Accessibility Adaptations (EEA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)
• Personal Emergency Response Systems (PERS)
• Transitional Case Management (TCM)
• Home Respite
• Waiver Personal Care Services (WPCS)

Minimum qualifications for a Non-Profit Organization functioning as an HCBS IHO Waiver Service Provider are:

1. The Executive Director/Program Manager responsible for the day-to-day management of the non-profit program possesses a Baccalaureate degree or higher, and training and experience in overseeing programs for the elderly and/or persons with disabilities living in the community, or have al least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher.

2. Filed a current "Statement of Information by Domestic Nonprofit Corporation" (Form SI-100 rev. 05/2005) with the California Secretary of State.

3. Annually files Form 990 financial reports with the California Attorney General's Registry of Charitable Trusts.

4. The Non-Profit Organization shall maintain General Liability and Workers' Compensation insurance at all times while serving as a waiver service provider.

5. The Non-Profit Organization is experienced in providing home and community-based services and support to the elderly and/or persons with disabilities living in the community.

6. The Non-Profit Organization is responsible for providing training and/or in-services to staff eligible to provide HCBS IHO Waiver services and at least annually reviews the HCBS IHO Waiver services requirements. Training of HCBS IHO Waiver service providers must be specific to the conditions and care of HCBS IHO Waiver participants served by the Non-Profit Organization.

7. Complies with the terms and conditions set forth in the Centers for Medicare & Medicaid Services (CMS) approved HCBS IHO Waiver.

8. The Non-Profit Organization is responsible for the maintenance of waiver participant case documentation and financial records which support the claims for waiver services for a minimum period of three years or as long as the participant is receiving billable waiver services as required in Part 45, Code of Federal Regulations §74.53.

9. If the Non-Profit Organization employs licensed persons such as Licensed Clinical Social Worker (LCSW), License Psychologist and/or Marriage Family Therapist (MFT), who will render waiver

services to waiver participants as requested and authorized, the licensed professional must meet the following criteria:

a. Maintains a current, unsuspended, unrevoked license to practice within his/her scope of licensure in the State of California. The Non-Profit Organization must maintain records of licensing for inspection and review by DHCS/IHO. The Non-Profit Organization must notify DHCS/IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

b. Have documented work experience that includes, at least, a minimum of 1000 hours experience in providing CM, TCM, CTS, HS, EAA, PERS, and/or MEOE to the elderly and/or persons with disabilities living in the community.

The Non-Profit Organization must maintain records and documentation of any and all requirements of the waiver/SOP for inspection and review by DHCS/IHO. The Non-Profit Organization must regularly monitor the license status of its licensed employees and report any changes to DHCS/IHO within 30 days of the change of licensure status. The Non-Profit Organization must also maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by DHCS/IHO.

10. Employs qualified professional providers to provide HCBS IHO CM/C, CTS, HS, EAA, PERS, TCM, and/or MEOE services to waiver participants as requested and authorized. The qualified professional providers must meet the following criteria:

a. Must have earned a Baccalaureate Degree or higher in Clinical Social Work or Social Welfare, Psychology, Marriage and Family Therapy, Rehabilitation Services or Gerontology from an accredited college or university.

b. Must have at least 1000 hours work experience providing CM/C, CTS, HS, EAA, PERS, TCM and/or MEOE services to the elderly and/or persons with disabilities living in the community.
The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for each of its qualified unlicensed professional providers for inspection and review by DHCS/IHO.

11. If the Non-Profit Organization employs qualified unlicensed providers to provide Habilitation Services, which may include activities commonly described as peer mentoring, they must be supervised by an individual with a Baccalaureate degree or higher or have at least 5 years of training and experience in overseeing programs for elderly and/or persons with disabilities living in the community in lieu of possessing a Baccalaureate degree or higher with 1000 hours experience in providing supervision to providers of services to the elderly and/or persons with disabilities living in the community, the unlicensed providers must meet the following criteria:

a. Have at least an Associate of Arts degree from an accredited college or university and have at least 1000 hours work experience in providing services to the elderly and/or persons with disabilities living in the community, or:

b. Have two years of experience in providing services to the elderly and/or persons with disabilities living in the community, through an organization or agency, or

c. Have one year experience as a Peer Counselor providing advocacy and services to elderly and/or persons with disabilities living within an institution or in the community, through and organization or agency.

The Non-Profit Organization must maintain adequate documentation of the minimum hours of work experience for the qualified professional supervisor and each of the unlicensed providers for inspection and review by DHCS/IHO.

12. The Non-Profit Organization must provide Case Management/Coordination services consistent with the participant's choice and interests, the primary care physician's orders and the IHO Waiver

Plan of Treatment (POT) within the licensed provider's scope of practice and/or the qualified professional's experience as follows:

a. Develop the IHO Waiver POT in collaboration with the participant. The plan shall be consistent with the participant's choice and interest, the assessment of the participant and the primary care physician's orders for care. Collaborate with the participant and the participant's primary care physician in the development of the POT to ensure the participant's choice, interests and medical care needs are addressed. The POT will identify all the choice and interests of the participant, services rendered to meet the needs of the participant, the providers of those services, and the expected outcomes; and

b. Facilitate the process of collaboration and assessment with the participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician and/or the case manager/coordinator of the participant's status to update or revise the POT as directed by the participant in collaboration with the primary care physician to reflect the current choices, interests and care needs of the participant. Assist the participant in accessing services that are beyond the licensed professional's scope of practice, credentialing, or experience. The POT must be updated and signed by the participant and the primary care physician no less frequently than once every six months.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

California Attorney General's Registry of Charitable Trusts

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transitional Case Management

Provider Category:

Individual

Provider Type:

HCBS Benefit Provider - Licensed Psychologist

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

NA

Other Standard *(specify):*

HCBS IHO Waiver Standards of Participation

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

• Case Management/Coordination (CM/C)
• Community Transition Service (CTS)
• Environmental Accessibility Adaptations (EAA)
• Habilitation Services (HS)
• Medical Equipment Operating Expenses (MEOE)

• Transitional Case Management (TCM)

A Licensed Psychologist who functions as an HCBS IHO Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California.

2. Have work experience that includes, at least a minimum of 1000 hours of experience in providing case management/coordination services to the elderly and/or persons with disabilities living in the community.

3. The Licensed Psychologist must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by DHCS/IHO.

4. Provide case management services within the scope of practice of a Licensed Psychologist consistent with the primary care physician's orders and the POT as authorized by DHCS/IHO as follows:

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

b. Facilitate the process of assessing the waiver participant at the frequency described in the POT for progress and response to the POT. Inform the primary care physician of the waiver participant's status and update or revise the POT as directed by the primary care physician to reflect the medical needs of the waiver participant, as determined by the primary care physician. Assist the waiver participant in accessing medical care services that are beyond the Licensed Psychologist's scope of practice. The POT must be updated and signed by the primary care physician no less frequently than once every six months.

Verification of Provider Qualifications

Entity Responsible for Verification:

California Board of Psychology

Frequency of Verification:

Biennially

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*

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

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

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

- (●) **No. Criminal history and/or background investigations are not required.**
- ( ) **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

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).**

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, step-parent(s), foster parent(s) of a minor, a spouse, or legal guardian of a waiver participant, hereto referred to as legal representative/legally responsible adult, may provide select HCBS IHO Waiver services.

DHCS/IHO will authorize the participant's legal representative/legally responsible adult to provide HCBS IHO Waiver services upon evidence the legal representative/legally responsible adult:

1) has an active Medi-Cal provider number with a HCBS waiver category of service indicator;

2) meets waiver licensing and/or certification requirements;

3) meets the HCBS provider standards described in Appendix C-4:4;

4) meets the HCBS IHO Waiver Standards of Participation; and

5) provides evidence of the inability to hire a local licensed professional who meets the service requirements in the participant's plan of treatment.

The evidence of inability to hire a local licensed professional must document that:
1) there are no available providers;

2) the participant lives in a remote or rural area experiencing shortages of licensed professionals;

3) the participant's waiver cost neutrality can be achieved or maintained only by using the legal

representative/legally responsible adult as the provider of the HCBS service;

4) attempts were made to enlist and retain a qualified provider, such as posting of classified advertisements, or contacting home health agencies or professional corporation; and

5) there is an accounting of interviews with potential providers including the reasons the provider was not selected or refused to provide the waiver service(s).

Legal representative/legally responsible adults who meet the Medi-Cal and HCBS IHO Waiver provider standards may provide the following HCBS IHO Waiver services:
• Case Management;
• Community Transition Services;
• Environmental Accessibility Adaptations;
• Family Training
• Private Duty Nursing
• Habilitation Services
• Home Respite
• Transitional Case Management
• Medical Equipment Operating Expense

DHCS/IHO will notify the waiver participant and/or his/her legal representative/legally responsible adult of the decision to approve or deny the legal representative/legally responsible adult's request to provide waiver services by either authorizing the requested service(s) or issuing a Notice of Action (NOA).

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

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

Continuous and open enrollment is afforded to any willing and qualified provider who meets Medi-Cal and HCBS IHO Waiver provider qualifications. Licensed providers must demonstrate they meet applicable state licensure requirements. Non-licensed providers must demonstrate they have the necessary skills to provide services as described on the POT. Information on how interested providers can become an HCBS IHO Waiver provider is available online at the Medi-Cal website under the Provider Enrollment Branch (PEB). Enrollment information is available in the Medi-Cal Provider Manual, which is distributed at statewide DHCS/IHO presentations, and available online. The HCBS IHO Waiver Standards of Participation (SOP) are included in this waiver application.

DHCS/IHO has expedited the provider enrollment process to ensure waiver participants have timely access to the HCBS IHO Waiver providers of his/her choice. PEB and DHCS/IHO have developed a provider information packet for licensed providers that includes:
- HCBS IHO Waiver Standards of Participation;
- Medi-Cal Provider Application forms and instructions;
- Forms and instructions for requesting authorization to provide HCBS IHO Waiver services;
- Forms and instructions for submitting claims for payment of approved HCBS IHO Waiver services that have been rendered; and
- Information on who to contact for questions or problems.

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

Annually, the DHCS/IHO NE verifies that the provider of waiver services continues to meet the waiver program requirements through onsite provider visits and a review of the provider status in the CA-MMIS Provider Master File for licensed providers, and Case Management Information Payrolling System (CMIPS) for non-licensed providers.

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 IHO Waiver providers that had timely written feedback from IHO NEII following a visit.

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percent of IHO Waiver providers that have the participant's chart current and up-to-date with a current physician signed POT.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Percent of IHO Waiver providers that received an annual visit by DHCS/IHO staff.

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**

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

Performance Measure:
Percent of IHO Waiver providers that were licensed and/or certified and/or meet the waiver provider requirements as described in Appendix C-3 for each provider type.

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

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

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

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

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

Specify:		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 partipant case files with documentation of the necessary skills, competencies and qualifications.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

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

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

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Percent of WPCS providers (non-licensed/non-certified individuals) that met the WPCS provider requirements prior to the provision of 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:

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 IHO Waiver provider files for RN and LVN providers that had a copy of a current and active nursing license, a current life support certification and documentation of current continuing education.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Percent of case files with documentation that the WPCS provider has been evaluated for specific training 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 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):*
	☐ **Weekly**	☑ **100% Review**

☑ **State Medicaid Agency**		
☐ **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.
Within 90 days of the review, the QAU will present an analysis of the findings to the DHCS/IHO Management Team. Based upon the findings and level of compliance, remediation actions will be developed and implemented by the DHCS/IHO Managers, Supervisors, and QAU within 90 days. If the findings show the compliance level to be 70% or below, special remedial actions will be developed and implemented within 30 days with follow up within 6 months. Effectiveness of general remedial actions will be re-evaluated at the next year's annual Case Record Review.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
DHCS/IHO has begun development of a Provider Satisfaction Survey. The survey is a mechanism to secure feedback from providers, to evaluate the provider's satisfaction of being a HCBS IHO Waiver provider, the effectiveness of the HCBS IHO Waiver services in supporting the participant's choice to receive care in his/her home and community in lieu of care in a facility, and solicit suggestions for improving the HCBS IHO Waiver and/or processes. The goal will be to conduct a survey in 2011.
The timeline for this action is as follows:

• 1/1/08 - 4/30/08 - Conduct research on the Provider Satisfaction Surveys and select a model. (COMPLETED)

• 1/1/10 - 7/31/10 - Develop a survey, instructions and evaluation criteria. Have the appropriate Branch managers review and approve the survey and instructions.

• 8/1/10 - 10/31/10 - Ask a small sample number of providers to review the survey and provide feedback.

• 11/1/10 - 12/31/10 - Make changes to the survey and instructions based upon the provider's feedback.

• 2/1/11 - 3/15/11 - Issue and collect the survey by mail with possible follow-up by DHCS/IHO NE staff to help ensure a reasonable percentage of input by providers.

• 3/16/11 - 4/30/11 - Analyze and evaluate the results of the survey by provider type and present recommendations to DHCS/IHO Management Team. Provide results and recommendations to the providers and solicit their input.

5/1/11 – 7/31/11 - Develop and implement a remediation plan based upon all input.

1/1/12 - 3/31/12 - QA Unit will follow up with providers to determine and document the effectiveness of any remedial or corrective action and determine the frequency of future Provider Satisfaction Surveys.

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.

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

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

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

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

(d) An increase in the participant's individual cost limit will only be allowed if there is a change in the participant's assessed needs resulting in an increase in their level of care (LOC). If the participant's change in LOC would result in an increase in cost limit the participant's maximum cost limit must correspond with the cost limit established by DHCS for that LOC and identified in the participant's MOHS. The change in the participant's assessed needs must be described on the current POT and coincide with an increase in the participant's level of care (LOC). A higher LOC with any increase in cost may necessitate transition to the NF/AH Waiver.

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

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

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

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

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

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.

The DHCS/IHO has identified and reviewed the IHO Waiver provider types and services pursuant to ensuring they meet the new Federal HCB settings requirements.

Since services in the IHO waiver are delivered within the participant's private home, the state therefore presumes that this dwelling meets the characteristics of home and community-based settings. Based on this assumption, the state concludes that there is no need for a transition plan.

As of October 2014, there are currently 125 Waiver Participants enrolled in the IHO Waiver.

The IHO Waiver provider types include all of the following:
• Durable Medical Equipment Provider
• Employment Agency
• Home Health Agency
• Licensed Clinical Social Worker
• Licensed Psychologist
• Licensed Vocational Nurse
• Marriage Family Therapist
• Personal Care Agency
• Private Nonprofit or Proprietary Agency
• Professional Corporation
• Registered Nurse
• Waiver Personal Care Services Provider

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Plan of Treatment (POT)

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

- [x] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [x] **Licensed physician (M.D. or D.O)**
- [x] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- [ ] **Social Worker**
  Specify qualifications:
- [ ] **Other**
  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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

- ○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

An HCBS IHO Waiver case management provider who meets the service requirements set forth in Appendix C-3 which includes the HCBS IHO Waiver Standards of Participation may provide other waiver services described in the Plan of Treatment (POT). The POT must be reviewed and signed by the primary care physician overseeing the participant's home program.
The primary care physician-signed POT must be current and updated at least every 180 days, or more often when the participant's health status and needs change. The waiver case manager is responsible for submitting the latest primary care physician-signed POT with each Treatment Authorization Request (TAR) for waiver services.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

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

(a) The DHCS/IHO NE provides the waiver participant, and/or his/her legal representative/legally responsible adult (s), and/or circle of support with information on the purpose of the POT and encourages them to participate in identifying his/her needs, services, and providers to support and ensure the safety of his/her home program. The information is provided verbally at the initial and ongoing face-to-face home visits, as well as in writing through the HCBS Informing Notice and MOHS. During the ongoing home visits, the DHCS/IHO NE reviews the POT with the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support to ensure the POT accurately reflects the participant's identified care needs, type and duration of services, and providers of the service.

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

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

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

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):

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

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

The participant's waiver case manager is responsible for completing the initial POT and updating it at least every 180 days thereafter. If after the completion of the initial POT it is determined that the POT does not meet the participant's needs due to significant changes in the participant's condition, the waiver case manager, consulting with the primary care physician, must submit an updated or revised primary care physician-signed POT to the DHCS/IHO NE. "Significant changes" are changes that suggest the need to modify the POT, such as changes in the participant's health status, home setting, or availability of waiver providers.

If the participant's only service is WPCS then the participant and/or his/her legal representative/legally responsible adult(s) and/or circle of support are responsible for developing the POT with the assistance of the IHO NE.

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

(b) Waiver case managers can use the "Long-Term Care Division, In-Home Operations, Plan of Treatment" or the CMS-485 Home Health Plan of Care for the POT.
The POT must include the participant's demographic information; treating and primary care physician information; medical information and diagnosis; HCBS waiver program and LOC; all required waiver services, including amount and frequency, and waiver service provider type; state plan services; durable medical equipment required; medication plan; nutritional requirements; the treatment plan for the home program; the participant's functional limitations; permitted activities; mental status; medical supplies; ongoing therapies and therapy referrals; treatment goals, including rehabilitation potential; service needs even if they are addressed outside the scope of the IHO waiver program and training needs for the participant and family.

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

The DHCS/IHO NE reviews the completed POT to verify the participant's care needs, the frequency of waiver and

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

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

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

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

The POT is developed based on information obtained from the nursing evaluation and the home safety evaluation. The latter demonstrates that the participant's home environment is safe and conducive to the successful implementation of a home and community-based services program. It includes an evaluation of risk factors affecting the participant's health and safety (e.g. sufficient care providers trained in the participant's care needs, effective back-up plan, evaluation for abuse, neglect and exploitation).

Identified conditions that may affect the participant's health, welfare, and/or safety require the waiver case manager to develop a plan of correction and provide evidence that the conditions are corrected. An approved POT will include the following information:

• Assurance that the area where the participant will be cared for can accommodate the use, maintenance, and cleaning of all medical devices, equipment, and storage supplies necessary to maintain the participant in the home in comfort and safety, and to facilitate the nursing care required;

• Assurance that primary and back-up utility, communication, and fire safety systems and devices are available, installed, and in working order, including grounded electrical outlets, smoke detectors, fire extinguisher, and telephone services;

• Evidence that local emergency and rescue services and utility services have been notified that a person with special needs resides in the home;

• Assurance that all medical equipment, supplies, primary and back-up systems, and other services and supports, are in place and available in working order, or have been ordered and will be in place at the time the participant is placed in the home;

• Documentation that the participant is not subjected to abuse, neglect, or exploitation and is knowledgeable of his/her rights and who to contact if incidents occur; and

• Documentation that the caregivers are knowledgeable of the care needs of the participant.

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 HCBS IHO Waiver can select any Medi-Cal provider who is willing to provide State Plan or waiver services and is qualified and enrolled as a waiver provider. The DHCS/IHO NE provides the participant and/or his/her legal representative/legally responsible adult(s) and/or members of his/her circle of support with a list of current HCBS waiver providers and information on how a non-HCBS waiver provider can enroll as a waiver provider. Additionally, the DHCS/IHO NE provides the participant and/or his/her legal

representative/legally responsible adult(s) with the MOHS, which includes the provider types authorized to provide approved waiver services.

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

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

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:

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.

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

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

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

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

•Verify the participant's POT is current and signed by the primary care physician. Copies of the current and past POTs are filed in the participant's case record.

• Verify the participant is receiving the services described in the POT, review the POT with the participant and/or his/her legal representative/legally responsible adults and/or members of his/her circle of support and discuss the recommendations for waiver and non-waiver services and providers of services.

• Ensure the POT meets the participant's health care needs and personal goals. During the on-site home visit the DHCS/IHO NE attempts to determine if the participant is receiving all the services identified in the POT, whether the participant is satisfied with the care being delivered, and if the participant is receiving the services needed to remain safely at home.

• Ensure a complete and accurate written medical record, including diagnoses, complete evaluation, treatment plan, and prognosis is available when determining the need for the HCBS waiver services described in the POT.

• Determine that waiver and non-waiver State Plan services provided do not exceed the waiver cost neutrality.

• Review the back-up plan in the event a provider is not available. The DHCS/IHO NE can assist the participant and/or his/her legal representative/legally responsible adults and/or members of his/her circle of support in identifying providers and community resources as part of his/her back-up plan.

• Document the participant and his/her legal representative/legally responsible adult are evaluated for and instructed on how to recognize and report abuse, neglect and exploitation. The POT reflects any risk for abuse, neglect and exploitation and how incidents will be prevented.

• Ensure the written home safety evaluation has been completed and all identified issues are addressed on the POT. The home safety evaluation assesses participant accessibility, structural barriers, utilities, evacuation plans, and communication and fire safety systems and devices.

• Document the participant's home is safe.

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

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

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

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

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

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 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**

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

Performance Measure:
Percent of case records that document that the participant, his/her legal representative and their circle of support were involved in the identification, development and management of services and supports for meeting the participant's needs.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percent of case records documenting that the participant's needs are being met and that the participant, their legal representitive and/or their circle of support are satisfied with the services being delivered.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure 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: 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.

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**

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

Performance Measure:
Percent of POTs modified due to the participant's changing 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**

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

Performance Measure:
Percent of case reports that document services are delivered as described on the POT.

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

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

Data Source (Select one):
Other

If 'Other' is selected, specify:
CMIS Database Tracking and Reporting System

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

Data Aggregation and Analysis:

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

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

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 reports with documentation that corrective action was taken if services were not delivered as described in the POT.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percent of case reports with documentation by the IHO NE indicating that services are being delivered as described in the POT.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure 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 reviewed that have copies of the Informing Notices indicating they have been sent to the participant, provider and primary care physician describing their responsibilities.

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

Responsible Party for data		**Sampling Approach** *(check each that applies):*

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

Data Aggregation and Analysis:

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

Performance Measure:
Percent of case records with a current MOHS that identifies all services described on 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:

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

Performance Measure:
Percent of IHO 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 indicating Medicaid freedom of choice as evidenced by the presence of a current MOHS which lists all waiver services and provider types and identifies the services and providers the participant or legal representative have selected.

Data Source (Select one):
Other

If 'Other' is selected, specify:
Menu of Health Services (MOHS)

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:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The DHCS/IHO Quality Assurance Unit (QAU) is responsible for developing discovery activities, as well as collecting, and analyzing the data from those activities. The DHCS/IHO Section Chief, Managers, Nurse Evaluator (NE) Supervisors, and QAU are responsible for the development, implementation, and evaluation of remediation actions.

The QAU utilizes the following tools for discovery:

• Internet-based Case Management Information Systems (CMIS);
• Case Record Review;

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

CMIS is a database developed and implemented in 2005. The QAU uses information from CMIS to establish quality indicators that help determine if changes need to be made to the waiver enrollment criteria, services, providers, or any other aspect of waiver administration. CMIS allows DHCS/IHO to document the utilization and cost of WPCS services as well as track Notice of Action (NOA) and capture the number of requests for state hearings along with the outcomes of those hearings.

The QAU is responsible for conducting the annual Case Record Reviews on active HCBS IHO Waiver cases. The selected sample size for the number of case records to be reviewed is determined by using the Sample Size Calculator located at: http://www.surveysystem.com/sscalc.htm.

The QAU randomly selects a sample of case records with a 95% level of confidence with a 5% interval for the entire IHO Waiver population. The waiver population includes all waiver participants that were open to the waiver anytime during the selected waiver year. Using the identified sample size indicated by the Sample Size Calculator, the QAU selects the cases for review based upon the corresponding percentage of participants at each level of care (LOC) by DHCS/IHO field office location and will ensure that all DHCS/ IHO NE staff are represented in the cases selected for review. The Case Record Review uses a Record Review Tool designed to document the following:
• Evidence of the accuracy of LOC evaluation;

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

• The POT appropriately addresses all of the participant's identified needs' and assures participant's health and welfare;

• The participant, and/or his/her legal representative/legally responsible adult(s)(s), and circle of support's knowledge of issues concerning abuse, neglect, and exploitation and how to report them;

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

• Information and support is available to help the participant, and/or his/her legal representative/legally responsible adult(s)(s) and/or circle of support to make selections among service options and providers;

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

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

• The DHCS/IHO NEs level of compliance with DHCS/IHO' policies and procedures in the completion and maintenance of the waiver participant's case report.

Using these tools, the QAU analyzes data for trends and patterns of populations served and make changes to policy, procedures, and resources based on that analysis. DHCS/IHO then develops any needed remedial actions deemed necessary to provide the best service to the HCBS waiver population while assuring compliance with waiver assurances as well as DHCS/IHO polices and procedures.

Within 90 days of the QA review, the QAU will present an analysis of the findings to the DHCS/IHO Management Team. The analysis will include an evaluation of the waiver's impact to the participant's health and welfare and identify any risks to the participant and how those risks will be managed. Based upon these findings and level of compliance, remediation actions will be developed and implemented by the DHCS/IHO Managers, Supervisors, and QAU within 90 days. Effectiveness of the remediation actions are measured

during the following year's annual Case Record Review. If the findings have a direct impact on a participant's health and safety the remediation actions will be measured within 90 days.

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.

HCBS IHO Waiver participants or their legal representative have the opportunity to hire and dismiss licensed and unlicensed providers who under the direction of the participant or legal representative can provide waiver services as described in Appendix C of this application. The ability to hire, dismiss and direct the services of the individual waiver providers supports:
•
-freedom of choice in the provider of waiver services;
• -flexibility in scheduling the services to meet the participant's needs;
• -continuity of care; and
• -ability to direct the services that meet the participant's needs.

DHCS/IHO provides information on the availability of this option to the participant or legal representative at the face-to-face intake assessment and reassessment visits. DHCS/IHO advises the participant or legal representative on the roles and responsibilities for the participant or legal representative, primary care physician who oversees the participant's home program, DHCS/IHO and the provider. Upon request DHCS/IHO will provide the participant, legal representative and potential wavier provider with the written requirements and process to:
• -enroll as a waiver provider;
• -provide waiver services; and
• -submit documentation for payment of services rendered.

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

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

• -Case Management
• -Habilitation Services
• -Community Transition Services
• -Private Duty Nursing
• -Transitional Case Management
• -Family Training
• -Respite Care

Participants or legal representative may hire individual licensed providers to facilitate the provision of and Medi-Cal billing for the following services:

• -Environmental Accessibility Adaptations
• -Personal Emergency Response Systems
• -Personal Emergency Response Systems – Installation and Testing
• -Medical Equipment Operating Expenses

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

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

Participants or legal representatives can obtain lists of unlicensed providers from their county's IHSS program, licensed providers from DHCS/IHO or they can select an unlicensed or licensed provider who is not enrolled as provider. Upon selecting a licensed or licensed provider, DHCS/IHO will advise the potential provider of the enrollment process and the roles and responsibilities of becoming a waiver provider.

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

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

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

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

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

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

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.

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

If the participant or legal representative expresses interest in hiring an unlicensed provider to provider WPCS and/or Respite services, DHCS/IHO provides the participant with a Waiver Personal Care Information Packet which describes the roles and responsibilities of the participant, legal representative, the participant's primary care physician, DHCS/IHO and the unlicensed provider. The packet includes information on the:
• -requirement for two or more personal care providers when a participant is authorized to receive 360 hours or more a month of combined IHSS PCS and WPCS;

• -waiver services can only be authorized upon DHCS/IHO receipt of a current, complete and signed POT;

• -participant or legal representative is responsible for scheduling the unlicensed provider''s hours of service;

• -participant or legal representative is responsible for signing the unlicensed provider''s timesheet validating the hours on the timesheet were provided; and

• -participant or legal representative is responsible for notifying DHCS/IHO upon the hiring and dismissal of providers.

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

• -roles and responsibilities of selecting an individual provider;

• -the participant or legal representative are responsible for scheduling the hours of service;

• -the provider can only provide the services as described on the primary care physician-signed POT; and

• -the participant or legal representative is responsibility for notifying HCBS/IHO upon the hiring or dismissal of providers.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

○ **The State does not provide for the direction of waiver services by a representative.**

◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☑ **Waiver services may be directed by a legal representative of the participant.**

☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Environmental Accessibility Adaptations	☑	☐
Community Transition Services	☑	☐
Waiver Personal Care Services (WPCS) and Personal Care Services	☑	☐
Facility Respite	☑	☐
Personal Emergency Response Systems (PERS)	☑	☐

Waiver Service	Employer Authority	Budget Authority
Habilitation Services	☑	☐
Private Duty Nursing - Including Shared Services	☑	☐
Medical Equipment Operating Expense	☑	☐
Family/Caregiver Training	☑	☐
Transitional Case Management	☑	☐
Personal Emergency Response (PERS) - Installation and Testing	☑	☐
Home Respite	☑	☐
Case Management/Coordination	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

○ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☐ **Private entities**

◉ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Answers provided in Appendix E-1-h indicate that you do not need to complete this section.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case Management service assists the participant in developing the POT, which is reviewed and signed by the participant's primary care physician. A primary care physician signed-POT is required prior to authorization or reauthorization of waiver services.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Environmental Accessibility Adaptations	☐
Community Transition Services	☐
Waiver Personal Care Services (WPCS) and Personal Care Services	☐
Facility Respite	☐
Personal Emergency Response Systems (PERS)	☐
Habilitation Services	☑
Private Duty Nursing - Including Shared Services	☐
Medical Equipment Operating Expense	☐
Family/Caregiver Training	☐
Transitional Case Management	☐
Personal Emergency Response (PERS) - Installation and Testing	☐
Home Respite	☐
Case Management/Coordination	☐

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

DHCS/IHO provides information and assistance to the waiver participants or legal representative. The information is provided verbally during the initial face-to-face assessment for waiver enrollment and at each reassessment visit. The information is also provided in writing in the Informing Notice and Menu of Health Services. Upon enrollment in the waiver, the participant is assigned a DHCS/IHO Case Manager (CM) who is a registered nurse.

The CM is required to advises the participant or legal representative of the option of selecting participant direction services and providers at each reassessment visits and at any time upon request from the participant or legal responsive. Evidence of participant being informed of the option is documented in the DHCS/IHO Case Report and copies of the Informing Notice and Menu of Health Services is filed in the participant's DHCS/IHO case record.

At each participant's reassessment visit the CM interviews the participant or legal representative as to the effectiveness of the provider's ability to provider the services as described on the POT. At each annual provider visit the CM assess the licensed provider's documentation of the services provided and the participant's response to the services that are being provided per the POT. Information from the interview on the provider's ability to provide the care is documented in the DHCS/IHO Case Report.

It is the responsibility of the participant or legal representative to assess the performance of the provider. The participant or legal representative are advised to inform DHCS/IHO of any issues or problems and to notify the appropriate law enforcement agency, child or adult proactive services, county IHSS office and/or licensing

board in the event of abuse, neglect and/or exploitation. Only the participant or their legal representative have the ability to hire or dismiss an individual provider.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

DHCS/IHO may elect to terminate authorization of participant directed services for the following reasons:
• -Lack of a current primary care physician-signed POT describing all the participants care services, provider of the services and the frequency of the services

• -Participant or legal representative require the provider to provide services that are not included in the POT or beyond to scope of practice of the licensed provider

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	125	
Year 2	120	
Year 3	115	
Year 4	110	
Year 5	106	

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:

The Department of Social Services (DSS) acts as the common law employer. Unlicensed providers must enroll as a IHSS PCS provider at the county's DSS office. Payment for WPCS is processed through the DSS Case Management Information Payrolling System (CMIPS).

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

- [x] **Recruit staff**
- [x] **Refer staff to agency for hiring (co-employer)**
- [x] **Select staff from worker registry**
- [ ] **Hire staff common law employer**
- [ ] **Verify staff qualifications**
- [ ] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- [ ] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [ ] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [ ] **Discharge staff (common law employer)**
- [x] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

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

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**

- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

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

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

The NOA advises the participant of DHCS/IHO's decision and the reason(s) to 1) terminate or deny waiver enrollment; 2) reduce or terminate previously authorized waiver services; or 3) deny new or previously authorized waiver services. The NOA includes instructions advising the participant and/or his/her authorized representative(s) on how to request a State Fair Hearing before an Administrative Law Judge (ALJ). The participant must request a State Fair Hearing within 90 calendar days after the date the NOA was mailed to the participant.

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

State Plan and waiver services unaffected by the NOA will continue to be provided as authorized. The participant's Medi-Cal eligibility is not affected by a NOA, unless the NOA was issued because the participant no longer met the waiver requirements or LOC, the participant obtained his/her
Medi-Cal eligibility through the waiver's income and resource eligibility requirements, or the participant no longer meets regular Medi-Cal eligibility requirements.
Upon request of a State Fair Hearing, DHCS/IHO staff will contact the participant and/or his/her legal representative/legally responsible adult(s) to provide them with additional information on the State Fair Hearing process, pursuant to the Welfare and Institute Codes 10950 et seq. and the California Code of Regulations, Title 22, Sections 50951 et seq., 51014.1 and 51014.2. DHCS/IHO staff will advise them they will receive the DHCS' written position statement before the scheduled hearing date. If the participant and/or his/her legal representative/legally responsible adult(s) have not identified legal representation, DHCS/IHO will refer the participant and/or his/her legal representative/legally responsible adult to the toll-free 800 telephone number listed on the back of the NOA for information regarding hearing rights and free legal aid and to Protection and Advocacy, Inc. DHCS/IHO will continue to work with the participant and/or his/her legal representative/legally responsible adult(s) to resolve the hearing issues before the fair hearing.
If the DHCS Director's Decision upholds DHCS/IHO's action to reduce, terminate, or deny continued enrollment in the waiver and/or a waiver service(s), any aid paid pending which the participant had been receiving will stop.

The participant can request a rehearing. Instructions on how to request and the grounds for a rehearing are included with the ALJ's written decision. To request a rehearing, the participant must mail a written request within 30 calendar days after receiving the final decision. The participant must state the date the decision was received and the reason(s) why a rehearing should be granted. A request may be granted if the participant submits evidence that was not reasonably available at the hearing that could impact the original decision.
If the participant is unsatisfied with the outcome of the original hearing or rehearing, they can elect to seek a judicial review by filing a petition in Superior Court within one year of receiving notice of the final decision. The participant may file this petition without asking for a rehearing.

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

• The enrollment cap for the waiver has been met for the current fiscal year (the individual will be placed on a wait list if they so choose.)

• The participant does not meet this waiver's enrollment criteria, as describe in Appendix B.

• The participant or the legal representative/legally responsible adult(s),have not identified Providers who can provide all the primary care physician-ordered services at the time of discharge from the acute hospital and attempts have been made by the HCBS waiver service provider and/or DHCS/IHO to assist in identifying providers without success.

• The beneficiary is not able to establish Medi-Cal eligibility.

• The beneficiary or the authorized representative, to the extent the beneficiary needs support, elects in writing to withdraw the request for service.

• The request for services exceeds 24 hours a day of direct care services.

• The beneficiary becomes deceased.

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

• The cost of the requested service(s) exceeds the cost of the individual's cost limit and the participant and/or the primary caregiver does not agree to a reduction in the requested services in order to maintain program cost neutrality;

• The participant loses Medi-Cal eligibility;

• The participant moves from the geographical area in which the HCBS IHO Waiver services were being authorized to a new area where there are providers of services, but no provider has agreed to render waiver services to the participant;

• The participant's medical condition resulting in frequent emergency hospitalization is unstable as demonstrated by repeated, unplanned hospitalizations, and the waiver does not provide enough support to ensure the participant's health and safety in the community;

• The participant's condition does not meet the medical eligibility criteria for the evaluated LOC described in the waiver;

• The participant or the legal representative/legally responsible adult(s) refuses to comply with the primary care physician's orders on the Plan of Treatment (POT), and DHCS/IHO determines that such compliance is necessary to assure the health, safety and welfare of the participant;

• The participant or the legal representative/legally responsible adult(s) does not cooperate in attaining or maintaining the POT goals which jeopardizes participant health and welfare;

• The identified support network system or the primary caregiver cannot be identified, is not able, or is no longer willing or available to assume the responsibility to act as a back-up for the participant. The DHCS/IHO NE will work with the participant and responsible persons to develop a POT and identify providers so the participant can continue to reside safely in a home-like setting, when possible;

• The home evaluation, completed by the HCBS provider, documents an environment that does not support the participant's health, safety and welfare, or is otherwise not conducive to the provision of HCBS waiver services;

• The HCBS waiver service provider is unwilling or unable to provide the amount of authorized services as ordered by the participant's POT and/or primary care physician's order. If this inability to provide services impacts the health and safety of the participant and, at the request of the participant and/or the legal representative/legally responsible adult(s), the DHCS/IHO shall assist with the authorization process for the participant by assisting and accessing the location of a licensed health care facility, until another HCBS waiver service provider accepts the responsibility for providing services in the home setting;

• Any documented incidence of noncompliance by the participant or legal representative/legally responsible adult(s)(s) with the requirements of this agreement that poses a threat to the health or safety of the participant, and/or any failure to comply with all regulatory requirements;

• The participant and/or his/her legal representative/legally responsible adult(s)(s) and/or circle of support are requesting direct care services that exceed 24 hours per day and do not agree to a reduction of services so as not to duplicate services;

• The participant receives 360 hours per month or greater of combined In-Home Supportive Services (IHSS) Personal Care Services (PCS) and WPCS services, and does not have two (2) or more personal care providers to protect the safety of the participant;

• The participant, legal representative/legally responsible adult(s)(s), primary care physician, or waiver service provider has not submitted to DHCS/IHO a complete and current primary care physician-signed POT within 90 days of the initial evaluation or within 60 days of the end-date of the previous POT; and

• DHCS/IHO has not received a TAR or the WPCS provider information within 90 days of the initial evaluation or within 60 days of the termination date of the last authorized waiver services.
In the event of a denial, reduction or termination of waiver services and/or enrollment, the DHCS/IHO NE will assist the participant in identifying local community resources that may be available.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

   - (●) **No. This Appendix does not apply**
   - ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair

Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

The Department of Health Care Services (DHCS)/In-Home Operations (IHO) Nurse Evaluator (NE) will document all reported or observed critical events or issues that may affect the health, safety and welfare of waiver participants. Critical events or incidents are those reported or observed of participant abuse (physical/sexual) or neglect, incidents posing an imminent danger to the participant, fraud or exploitation (including misuse of

participant's funds and/or property), or a dangerous physical environment. The DHCS/IHO NE provides instruction to the participant, his/her legal representative/legally responsible adult(s) and/or members of his/her circle of support on how to report events or issues that affect or can affect the health, safety and welfare of the waiver participant.

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

The Event/Issue Report form is designed to document:

• A description of the event or issue (the who, what, when and where);

• Who reported the event or issue;

• The State and local agencies, the primary care physician, and law enforcement who were notified and when;

• The plan of action to address/resolve the event or issue (who, what, when); and

• The resolution and date resolved.

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

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

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

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

• Failure by the Medi-Cal provider to report abuse or neglect of a waiver participant. L&C will also notify the appropriate local or State agencies;

• Failure to notify the primary care physician of a change in the participant's condition, if the participant is harmed by the failure of this action;

• Failure to inform the participant and/or his/her legal representative/legally responsible adult(s)s of the participant's "Patient Rights",;

• Failure to comply with the participant's "Patient Rights";

• Failure to complete the appropriate documentation and/or notify the participant's primary care physician of an incident;

• Failure to provide services or supplies as described on the POT, ordered by the primary care physician and agreed

to provide;

• Inadequate or inappropriate evaluation of the participant's needs (e.g., weight loss not assessed),;

• Inadequate notification to the participant when services or supplies are changed or terminated; and,

• Failure to act within a professional's scope of practice.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

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

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

The DHCS/IHO NE is responsible for monitoring and ensuring the health, safety and welfare of waiver participants. If the DHCS/IHO NE determines that the primary care physician has not authorized the use of restraints or seclusion, or the use of the restraints or seclusion 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 or seclusion by a HHA, ADHC, and/or PDHC is referred to DPH L&C to investigate and report on their findings. The DHCS/IHO NE is responsible for monitoring the outcome of DPH L&C 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 DHCS/IHO NE is responsible for monitoring and ensuring the health, safety and welfare of waiver participants. This is accomplished through initial, scheduled, or unscheduled home visits by the DHCS/IHO NE and/or via telephone contact with participants, his/her legal representative/legally responsible adult(s), IHO Waiver providers, and primary care physicians. If the IHO Waiver provider or the DHCS/IHO NE 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 Restrictive Interventions by a HHA, ADHC, and/or PDHC is referred to DPH L&C to investigate and report on their findings. The DHCS/IHO NE is responsible for monitoring the outcome of DPH L&C 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 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).

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

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

The DHCS/IHO NE is responsible for monitoring and ensuring the health, safety and welfare of waiver participants. If the DHCS/IHO NE determines that the primary care physician has not authorized the use of restraints or seclusion, or the use of the restraints or seclusion 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 or seclusion by a HHA, ADHC, and/or PDHC is referred to DPH L&C to investigate and report on their findings. The DHCS/IHO NE is responsible for monitoring the outcome of DPH L&C investigation and findings.

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.

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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. **Medication Administration by Waiver Providers**

Answers provided in G-3-a indicate you do not need to complete this section

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).

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

- ( ) **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

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

Appendix 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 case records documenting the NE has discussed recognizing instances of abuse, neglect or exploitation with the participant, family and/or circle of support.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Percent of case records documenting 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**

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

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.

Performance Measure:
Percent of IHO Waiver cases meeting IHO's policies and procedures requiring issues or events to be documented in the Event/Issue database.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number of events/issues reported in the Event/Issue database by type

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

		☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Percent of events/issues that have documentation indicating they have been resolved during the previous year.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Source (Select one):
Program logs
If 'Other' is selected, specify:

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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.

Performance Measure:
Percentage of case records in which the use of restraints or seclusion is ordered by the primary care physician

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 = 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:

Percentage of case records in which the use of restraints or seclusion are listed in the POT

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 = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Percentage of case records in which an Event/Issue Report has been completed for the use of restraints or seclusion

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 = 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**

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

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.

Performance Measure:
n/a

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

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**

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

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.

In the current quality system, CMS requires that DHCS/IHO investigate whenever a performance indicator falls below a threshold of 86%. Any performance measure with less than an 86% success rate warrants further analysis to determine the cause. A Quality Improvement Project (QIP) must be implemented once the cause is found unless the DHCS/IHO provides justification accepted by CMS that a QIP is not necessary. DHCS/IHO will be sure to seek stakeholder involvement in the development of QIPs.

The DHCS/IHO Management Team is responsible for establishing priorities, remediation, and improvement actions. DHCS/IHO has established the following Levels of Compliance that are used to determine when remediation and improvement actions will occur. These levels of compliance are applied to all reports and reviews except those having to do with participant health and safety. DHCS/IHO' expectation is 100% compliance in that area.

80%- 100% - Substantial compliance with DHCS/IHO Policy & Procedures. No significant remediation actions required.

70%-80% - Compliant with DHCS/IHO Policy & Procedures, but raises concerns, additional investigation is needed. Remediation action and follow-up focus review as needed.

60%-70% - Marginally compliant with DHCS/IHO Policy & Procedures, remediation action and follow-up focus review required.

Less than 60% - Non-compliant with DHCS/IHO Policy & Procedures, remediation action and follow-up focus review is required.

Regardless of the level of compliance, program issues that affect the immediate health and safety of the participants will receive priority. The issue will be brought to the attention of the Management Team and a

remediation plan will be developed and implemented. The remediation plan may include contacting other agencies and State Departments for assistance, discussion at quarterly Olmstead Advisory Stakeholder meetings, changes to DHCS/IHO' policies and procedures and/or requesting assistance from CMS.

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

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

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

Home Visit Overdue Report
List of participants whose re-evaluation visit is over due by 30 days or more
Frequency - Monthly, Quarterly, Annually
Recipients of Report - Supervisors, DHCS/IHO Management

Provider Visit Overdue Report
Annual Provider visit is overdue by 30 days or more
Frequency - Monthly, Quarterly, Annually
Recipients of Report - Supervisors, DHCS/IHO Management

Event/Issue Report
By issue, amount of time to resolve, and participant satisfaction
Bi-annual, Annually
Recipients of Report - DHCS/IHO Management

Fair Hearing Report
By issue and outcomes
Annually
Recipients of Report - DHCS/IHO Management

Outreach Activities
List of outreach activities, who attended, and average evaluation scores.
Annually
Recipients of Report - DHCS/IHO Management

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The QAU is responsible for the measurement of performance, providing analysis when performance falls below the established Levels of Compliance, as described below, and the presentation of recommendations for remediation and improvement to DHCS/IHO' Management Team. In evaluating performance that falls below the established standards, the QAU will determine the cause of the problem or lack of documentation through interviews with the DHCS/IHO NE who are responsible for evaluating the participant's LOC, overseeing the POT to ensure it meets the participant's medical care needs, reporting issues that affect the health and safety of the participants, and ensuring the waiver providers meet the HCBS IHO Waiver's requirement. The Supervisors are also interviewed, as they are responsible for approving the LOC determinations and evaluating the documentation on the Case Report and Provider Visit Reports for completeness. The results of the interviews will be provided to the DHCS/IHO Management Team for the development of remedial actions. Based upon the need, remediation actions will be developed and implemented by the QAU and Management Team.

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

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

DHCS/IHO conducts annual statewide meetings, as the budget permits, to provide training and updates to all DHCS/IHO staff. Based on areas of need identified by QAU reviews and requests by DHCS/IHO staff, DHCS/IHO locates speakers, identified by DHCS as leaders in their field of expertise, to provide training during these meetings. These training sessions could include such varied subjects as dealing with provider billing issues, elder and dependent abuse in the home setting, or communication issues. Evaluations are collected to determine if the training goals and objectives have been met. The meeting's minutes will also be reviewed annually by the QAU and a summary of identified issues, remedial actions and follow-up activities will be described in the annual CMS 373 Q report.

The QAU us responsible for generating cost reports using the participant's identification number and service identifiers for cost reports for HCBS and State Plan services. The QAU will also run cost reports on Medi-Cal beneficiaries who are receiving long term care in an HCBS IHO Waiver's facility alternative. The results of these reports are analyzed by the QAU for trends and patterns across populations and reported to DHCS/IHO Section Chief, Managers and Supervisors. Evidence of remedial actions will be described in the annual CMS 373 Q report.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The QAU and participants of the Case Record and Provider Visit Review conduct a post-review evaluation of the review process and evaluation tools within 90 days after the review. Based upon the evaluation, the Case Record, Provider Visit Review Tools and instructions may be revised to remove items that have a history of significant compliance and add new items that have been identified as a potential issue or problem, and modify policies and procedures for how a specific issue is reviewed. DHCS/IHO will conduct a post-review of the implementation of the Provider Satisfaction Survey in the third quarter of 2011 and the Claims Quality Management Strategy in the first quarter of 2011. Changes to any of the above processes will be described in the annual CMS 373 Q report.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

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

Payments for waiver services are made through the approved California Medicaid Management Information System (CA-MMIS). The DHCS Fiscal Intermediary and Contracts Oversight Division (FICOD)administers the Medi-Cal claiming system and manages the State's third party fiscal intermediary contract that is currently with Hewlett-Packard (HP)Enterprise Services.

Health Insurance and Portability and Accountability Act (HIPPA) Compliant HCPCS Codes are unique to each waiver service. Each provider type is only eligible to bill for the waiver services they render. The billing is via standardized billing forms and claims are submitted to HP Enterprise Services for payment. Only recognized Medi-Cal billers may be paid for waiver services.

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

DHCS Audits & Investigations (A&I) Division is responsible for ensuring the fiscal integrity and medical necessity of Medi-Cal program services, including the HCBS IHO Waiver program. All claims submitted by waiver and State Plan providers are subject to random review regardless of provider type, specialty, or service rendered. A&I verifies that claims selected have sufficient documentation to approve the claim for payment. Providers are notified if a claim requires additional documentation before approval for payment. Failure to comply with the request for additional documentation may result in suspension from the Medi-Cal program, pursuant to Welfare and Institutions Code, Section 14124.2. A&I has three branches that conduct reviews using various methodologies to ensure program integrity and the validity of claims for reimbursement.

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

MRB also conducts Medi-Cal provider anti-fraud activities that include performing field reviews on new Medi-Cal providers and providers undergoing re-enrollment. MRB is charged with bringing closure to sanctioned providers through audits designed to quantify the abuse, settlement agreement, or permissive suspensions (exclusions) from the Medi-Cal program.

MRB staff work closely with HP Enterprise Services 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.

Waiver Personal Care Services (WPCS) claims are paid through the California Department of Social Services (CDSS), In-Home Supportive Services (IHSS) program, Case Management Information Payrolling System (CMIPS), developed and managed by HP Enterprise Services.

DHCS examines the provider records and compares the records with the authorized services. If the received claim is correct, IHO Quality Assurance (QA) staff will authorize payment through CMIPS. IHO QA 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, random audits of all Medi-Cal, IHSS and WPCS billers to ensure competency and accuracy in the paid claims.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(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:
Percentage of MOHS that were cost neutral to the Annual "G" Factor.

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

Responsible Party for data		**Sampling Approach** *(check each that applies):*

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

Data Aggregation and Analysis:

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

Performance Measure:
Percent of WPCS timesheets with the same hours approved for payment as those authorized on the WPCS authorization form in the case file.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Percentage of MOHS that contained the same number of authorized waiver services, the same provider types and the same State Plan services as those described on the current POT.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Percent of MOHS that contained the same number of WPCS hours as those listed on the WPCS Authorization form and the CMIS Summary.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percent of MOHS that contained the same number of waiver services and the same provider types as those authorized on the most recent TAR.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percent of MOHS that were current with the date of the last home visit.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **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.
The DHCS QAU currently conducts ad hoc discovery activities based upon a provider's complaint of non-payment and the suspicion of fraud. The QAU will access either the Surveillance and Utilization Review Subsystem (SURS) or the CMIPS to obtain evidence that a claim was submitted by an HCBS IHO Waiver provider for prior authorization of HCBS IHO Waiver services and was reimbursed at the established rate for the service. The evidence is submitted to the DHCS IHO Management Team to determine what, if any, further action maybe required. For issues concerning fraud, the QAU notifies the A&I. For issues concerning non-payment for all but WPCS, the QAU, the IHO NE, Supervisors or Managers will assist the provider in resolving issues concerning the authorization of services. For issues beyond DHCS/IHO' ability to remedy, the provider will be referred to the HP Enterprise Services Help Desk and/or Small Provider Billing Unit (SPBU). For non-payment of DHCS/IHO authorized WPCS services, the provider will be referred to the California Department of Social Services' IHSS program.

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

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

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

○ **No**
◉ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
Prior to 9/2010, DHCS IHO will contact the DHCS Audit Coordinator and start the process for an internal audit of IHO Waiver Claims by a State Agency other that IHO. IHO proposes scheduling this type of an audit at least once during the life of the waiver.

Also in 2010, DHCS/IHO will begin development of a Claims Quality Management strategy for reviewing HCBS IHO Waiver claims for allowability, allocability and accuracy of waiver services billed for purposes of claiming FFP. The quality management strategy will include the following elements:

• Determining the sample size of claims to be reviewed;

• Establish processes for accessing the claims data in SURS and CMIPS;

• Determine if the provider submitting the claim is a qualified HCBS IHO Waiver provider.

• Determine if the reimbursement rate matches the established rate for the service, as noted in the Medi-Cal Provider Manual or CMIPS; and

• Determine if the services were prior authorized in:
o CA-MMIS,
o Service Utilization Review Guidance and Evaluation (SURGE), or
o CMIPS

The QAU will conduct the review annually and provide the DHCS/IHO Management Team with the results within 30 days of the completion of the review. Based upon the results and the level of compliance, the DHCS/IHO Managers and Supervisors will develop and implement remediation activities within 60 days. Effectiveness of the remediation actions will be measured at the next year's annual review.

The timeline for this action is as follows:

1/1/10-3/31/10 – Conduct research on other claims discovery processes.

4/1/10-6/30/10 – Develop a Claims Review Tool. Conduct a test of the review tool to determine if the tool captures the information needed to determine if the claims are paid accurately and to an approved HCBS Waiver provider.

7/1/10-9/30/10– Make changes to the Claims Review Tool based upon the test. Determine the average number of HCBS IHO Waiver claims processed a year and determine a sample size of claims to be reviewed.

10/1/10-10/30/10 - Conduct a review on the representative sample of claims.

11/1/10-12/15/10 – Complete an analysis of the review and present recommendations to the DHCS/IHO Management Team.

1/2/11 – 3/1/11 – Develop and implement remediation actions as needed based upon the results of the review.

9/2011 – Implement the annual Claims Review

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

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

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

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

1. For non-physician services, RDB surveys the federal Medicare Part B program to assure that the Medi-Cal rates of reimbursement do not exceed the lowest maximum allowance for the same Medi-Cal State Plan service;

2. Review of standards of care prescribed under state statutes and regulations and identification of service providers;

3. Identification of cost factors;

4. Identification of at least seven states offering a similar type of service, and determining the average rate of reimbursement; and

5. Market survey and identification of rates of reimbursement by governmental and non-governmental third-party payers for the same or similar services.

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

DHCS/IHO uses three methods to establish rates for HCBS IHO Waiver services, which are based on provider type and the service provided:

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

Below is a description of the rate methodology used to establish payment rates for HCBS IHO Waiver services.

RATE METHODOLOGY
Adoption of published service rates for similar State Plan services

HCBS SERVICE
• Case Management
• Family Training
• Habilitative Services
• Private Duty Nursing - HCBS Nursing Facility
• Respite

RATE METHODOLOGY
Hourly rates established locally by county government/authorities

HCBS SERVICE
• Waiver Personal Care Services (WPCS)

RATE METHODOLOGY
By report for prior authorized services

HCBS SERVICE
• Environmental Accessibility Adaptations
• Personal Emergency Response (PERS) (activation and monthly service charge)
• Medical Equipment Operating Expense

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

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

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

DHCS/IHO is responsible for prior authorization of all HCBS IHO Waiver services and verifies that the requested services are in accordance with the participant's Plan of Treatment (POT). HCBS IHO Waiver service providers are responsible for submitting a Treatment Authorization Request (TAR) to DHCS/IHO for prior authorization of all

HCBS IHO Waiver services except the WPCS benefit. The DHCS/IHO NE reviews the TAR for medical necessity and to ensure services are authorized in accordance with the participant's POT. Claims for services are paid after the service is rendered.

DHCS Fiscal Intermediary and Contracts Oversite Division (FICOD) has overall responsibility for ensuring payment of Medi-Cal claims for authorized services. FICOD oversees the contract with HP Enterprise Services, the state's Medi-Cal fiscal intermediary responsible for managing the Centers for Medicare & Medicaid Services (CMS) approved CA-MMIS.

HCBS IHO Waiver providers submit claims to HP Enterprise Services for services rendered using either a CMS 1500 or UB 92 claim form. These claims are subject to all established requirements for processing directly through the CA-MMIS system. HP Enterprise Services adjudicates claims for services, resulting in one of four possible actions:
1. Paid (claim is paid);
2. Denied (claim is denied);
3. Suspended (HP Enterprise Services 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. HP Enterprise Services forwards a payment tape weekly to the State Controller's office for a checkwrite and the provider is notified through a Remittance Advice Detail form.

WPCS claims are paid through the California Department of Social Services (CDSS), In-Home Supportive Services (IHSS), Case Management Information Payrolling System (CMIPS), developed and managed by HP Enterprise Services.

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

WPCS providers submit monthly timesheets signed by the waiver participant or his/her legal representative/legally responsible adult(s) to the DHCS/IHO Northern Region office for review and approval. The timesheets are reconciled with the hours authorized in accordance with the waiver participant's POT. DHCS/IHO staff access the HCBS benefit section of CMIPS to authorize payment for claimed hours of service, documenting the hours worked, the rate of payment, and the gross amount approved for payment. The CMIPS system generates a payment tape daily that is sent to the State Controller's office where a payroll warrant is issued to the provider.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

- [ ] **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

DHCS/IHO is responsible for prior authorization of all HCBS IHO Waiver services and verification that the requested services are in accordance with the participant's POT.

Claims for waiver services must meet either the CA-MMIS or CMIPS requirements for processing, including program edits and audits. Submitted claims are reviewed to ensure that all required information is present.

Completed claims processed through CA-MMIS are run against system edits and audits to verify:
• Services are prior authorized;
• Participant is a Medi-Cal beneficiary and is enrolled in the HCBS IHO Waiver;
• Satisfactory Medi-Cal eligibility status;
• Provider is an enrolled Medi-Cal HCBS Waiver provider;
• Claim is not a duplicate;
• Claim is paid per the published rates or DHCS/IHO negotiated rate;
• Participant was not institutionalized during the time covered by the claim; and
• Appropriate HCBS IHO Waiver procedure codes.

Completed WPCS claims processed through CMIPS are run against system edits and audits to verify:

• Services are prior authorized;

• Participant is authorized to receive services through IHSS and is enrolled in the HCBS IHO Waiver program;

• Provider is enrolled as an IHSS provider authorized to provide services to the HCBS IHO Waiver participant;

• Claim is not a duplicate;

• Claim does not exceed maximum authorized hours; and

• Participant was not institutionalized during the time covered by the claim.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- ○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ◉ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

(a) The WPCS waiver benefit is not paid through the CA-MMIS.

(b) WPCS provider time sheets are sent to the DHCS/IHO Northern Regional office in Sacramento. DHCS/IHO staff verifies eligibility for WPCS services, the county pay rate, and check the hours submitted for payment against hours authorized. DHCS/IHO staff then calculates a payment amount due to the provider and enters the authorization number and payment information into the WPCS segment of CMIPS.

(c) DSS, through an interagency agreement, provides payment to the WPCS providers through CMIPS, a system developed by HP Enterprise Services for use by DSS in processing claims for providers enrolled in the IHSS program. CMIPS captures service evaluation information, issues Notices of Action (NOA), interfaces with the Medi-Cal Eligibility Data System (MEDS), generates management utilization and expenditure reports, and captures claim payment history. The CMIPS system generates a payment tape daily that is sent to the Office of the State Controller where a warrant is issued to the provider.

(d) DHCS reimburses DSS for making payments for the authorized WPCS hours under the HCBS IHO Waiver. DSS provides DHCS data tapes for reconciliation of payments for WPCS services. The accuracy and timeliness of payments to WPCS providers are monitored through CMIPS.

- ○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- ◉ **No. The State does not make supplemental or enhanced payments for waiver services.**
- ○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ○ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. **Organized Health Care Delivery System.** *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the 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 Home and Community-Based Continuous Care Facility (HCBCCF) the waiver participant pays the HCBCCF directly for the provision of room and board at the beginning of the month from his/her SSI/SSP income, retaining the Personal Needs Allowance as governed by regulation. The HCBCCF bill's the Medi-Cal program for the care rendered at the end of the month, only billing for the days in which the participant was enrolled in the NF/AH Waiver.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

iii. **Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. **Co-Payment Requirements.**

iv. **Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-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: Nursing Facility

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	80745.41	33502.00	114247.41	157862.00	7971.00	165833.00	51585.59
2	79125.65	34172.00	113297.65	161020.00	8130.00	169150.00	55852.35
3	78197.00	34855.00	113052.00	164240.00	8293.00	172533.00	59481.00
4	77775.47	35552.00	113327.47	167525.00	8459.00	175984.00	62656.53
5	77548.80	36263.00	113811.80	170875.00	8628.00	179503.00	65691.20

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: Nursing Facility
Year 1	125	125
Year 2	120	120
Year 3	115	115
Year 4	110	110

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:
		Nursing Facility
Year 5	106	106

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:

•DHCS/IHO waiver enrollment experience shows that participants enrolled in a waiver will maintain continuous enrollment until forced to leave due to illness or death.
The ALOS is expected to remain constant each waiver year.

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:

Factor D utilizations of waiver services were derived using assumptions from the 372 reports for the:

IHO Waiver
•WY 3 (January 1, 2009 – December 31, 2009) (3 Year Waiver)
•WY 1 (January 1, 2010 – December 31, 2010)
•WY 2 (January 1, 2011 – December 31, 2011)

The IHO Waiver was conceived as a method of shifting individuals whose care needs and authorized services placed them outside the cost neutrality requirements for their original waivers into a waiver where their cost neutrality would be calculated in the aggregate rather than individually. In most cases these individuals had maintained their current services levels since January 1, 2001.

The Average Cost/Unit for Case Management was increased to $42.60. The Case Management Average Cost/Unit for T1016 HCBS RN (67) was incorrectly published at $8.94 and was used to determine the Average Cost/Unit for Case Management in the prior waiver renewal. The correct rate for T1016 HCBS RN (67) is $9.94. The rate for T1016 HHA (14) is $11.36. The calculation for the Hourly Rate for Case Management is ((11.36+9.94)/2)*4=$42.60.
The Factor D utilization for existing waiver services are derived from experience as reported in the CMS 372 report for the IHO Waiver.

CMS 372 reports used:
IHO Waiver
••WY 3 (January 1, 2009 – December 31, 2009) (3 Year Waiver)
•WY 1 (January 1, 2010 – December 31, 2010)
•WY 2 (January 1, 2011 – December 31, 2011)

DHCS IHO does not expect any changes to these assumptions except a declining enrollment. The HCBS IHO Waiver enrollment has declined by 34% since it was approved on 01/01/2007.

The following are assumptions used in deriving the Factor D:

•DHCS IHO assumes that enrollment will decline by 4.1% percent annually.

•Utilization of Case Management Services is projected to decrease as participants shift over to lower cost WPCS services.
•
Waiver participants under 21 years of age receive waiver services when like services are not available through the State plan.

•Environmental Accessibility Adaptations benefit is capped at a lifetime benefit of $5,000.00.

•The Medical Equipment Operating Expense is limited to that portion of the utility bills directly attributable to operation of life sustaining medical equipment in the participant's place of residence. The minimum monthly amount of reimbursement will be $20.00 a month with a maximum monthly amount of $75.00. For purposes of completing Appendix J-d, an average of $25.00 is used based on reported utilization obtained from the CMS 372 reports.

•The average reimbursement rate for a waiver service is derived from averaging rates of reimbursement for the different providers providing a waiver service.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor D' estimates for State Plan services are derived from experience as reported in the CMS 372 reports for the IHO waiver. Other assumptions used for obtaining the aggregate Factor D', and for each level of care (LOC) described in this waiver are described below.

CMS 372 reports used:

IHO Waiver
•WY 3 (January 1, 2009 – December 31, 2009)
•WY 1 (January 1, 2010 – December 31, 2010)
•WY 2 (January 1, 2011 – December 31, 2011)

The following are assumptions used in deriving the Factor D':

The Factor D' costs are projected to increase by 2% based on the average inflation rate from 2010-2014.

The cost of all State Plan services furnished in addition to waiver services while the participant was on the waiver, including, but not limited to:

• State Plan home health services;

• State Plan personal care services authorized through the county's In Home Supportive Services program;

• Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services;

• Adult day health care;

• Short-term institutionalization (hospitalization or Nursing Facility) which began after the participant's first day of waiver services and ended before the end of the waiver year, if the person returned to the waiver.

• Medical equipment and supplies covered under the State Plan;

• Non-emergency transportation services covered under the State Plan; and

• Outpatient clinic and physician services covered under the State Plan.

• Medicare Part D drug costs are not included in the Factor D' estimates.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G estimates for inpatient NF Distinct Part and NF Subacute LOC are derived from the State's daily institutional costs for 365 consecutive days. Other assumptions used for obtaining the aggregate Factor G, and for each level of care described in this waiver are described below.

CMS 372 reports used:

IHO Waiver
•WY 3 (January 1, 2009 – December 31, 2009)
•WY 1 (January 1, 2010 – December 31, 2010)
•WY 2 (January 1, 2011 – December 31, 2011)

The following assumption is used in deriving the Factor G:

Factor G reflects the peer group for participants in this waiver. Participants in the HCBS IHO Waiver have an average LOS of 365 days as these participants have been continuously enrolled in a DHCS/IHO-administered waiver and have been receiving continuous HCBS waivers services since prior to January 1, 2001.

The Factor G (inpatient costs) are projected to increase by 2% based on the average inflation rate from 2010-2014.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G' estimates for State Plan services utilization during an inpatient NF A/B, NF subacute LOC from experience as reported in past CMS 372 report. Other assumptions used for obtaining the aggregate Factor G', and for each level of care described in this waiver are described below.

CMS 372 reports used:

IHO Waiver
•WY 3 (January 1, 2009 – December 31, 2009)
•WY 1 (January 1, 2010 – December 31, 2010)
•WY 2 (January 1, 2011 – December 31, 2011)

The following are assumptions used in deriving the Factor G':

• The cost of all State Plan services furnished during an inpatient stay.

• Factor G' is projected to increase by 2% based on the average inflation rate from 2010-2014.

Medicare Part D drug costs are not included in the Factor G' estimates.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Case Management/Coordination	

Waiver Services	
Habilitation Services	
Home Respite	
Waiver Personal Care Services (WPCS) and Personal Care Services	
Community Transition 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 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:						**55141.44**
Case Management/Coordination	Hours	80	16.18	42.60	**55141.44**	
Habilitation Services Total:						**3068.00**
Habilitation Services	Hours	1	100.00	30.68	**3068.00**	
Home Respite Total:						**944.80**
Home Respite	Hours	1	40.00	23.62	**944.80**	
Waiver Personal Care Services (WPCS) and Personal Care Services Total:						**2613594.79**
Waiver Personal Care Services (WPCS) and Personal Care Services	Hours	56	4185.77	11.15	**2613594.79**	
Community Transition Services Total:						**5000.00**
Community Transition Services	Event	1	1.00	5000.00	**5000.00**	
				GRAND TOTAL:		**10093176.11**
				Total Estimated Unduplicated Participants:		**125**
				Factor D (Divide total by number of participants):		**80745.41**
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations Total:						**5000.00**
Environmental Accessibility Adaptations	Event	1	1.00	5000.00	**5000.00**	
Facility Respite Total:						**1114.50**
Facility Respite	Days	1	5.00	222.90	**1114.50**	
Family/Caregiver Training Total:						**324.80**
Family/Caregiver Training	Hours	1	8.00	40.60	**324.80**	
Medical Equipment Operating Expense Total:						**250.00**
Medical Equipment Operating Expense	Months	1	10.00	25.00	**250.00**	
Personal Emergency Response (PERS) - Installation and Testing Total:						**35.00**
Personal Emergency Response (PERS) - Installation and Testing	Event	1	1.00	35.00	**35.00**	
Personal Emergency Response Systems (PERS) Total:						**378.12**
Personal Emergency Response Systems (PERS)	Months	1	12.00	31.51	**378.12**	
Private Duty Nursing - Including Shared Services Total:						**7407837.46**
LVN	Hours	55	3868.57	26.92	**5727804.74**	
CHHA	Hours	16	3475.57	18.90	**1051012.37**	
RN	Hours	10	1734.75	36.26	**629020.35**	
Transitional Case Management Total:						**487.20**
Transitional Case Management	Hours	1	12.00	40.60	**487.20**	
			GRAND TOTAL:			**10093176.11**
			Total Estimated Unduplicated Participants:			**125**
			Factor D (Divide total by number of participants):			**80745.41**
			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:						**46253.38**
Case Management/Coordination	Hours	72	15.08	42.60	**46253.38**	
Habilitation Services Total:						**3068.00**
Habilitation Services	Hours	1	100.00	30.68	**3068.00**	
Home Respite Total:						**944.80**
Home Respite	Hours	1	40.00	23.62	**944.80**	
Waiver Personal Care Services (WPCS) and Personal Care Services Total:						**2735732.78**
Waiver Personal Care Services (WPCS) and Personal Care Services	Hours	55	4461.04	11.15	**2735732.78**	
Community Transition Services Total:						**5000.00**
Community Transition Services	Event	1	1.00	5000.00	**5000.00**	
Environmental Accessibility Adaptations Total:						**5000.00**
Environmental Accessibility Adaptations	Event	1	1.00	5000.00	**5000.00**	
Facility Respite Total:						**1114.50**
Facility Respite	Days	1	5.00	222.90	**1114.50**	
Family/Caregiver Training Total:						**324.80**
Family/Caregiver Training	Hours	1	8.00	40.60	**324.80**	
Medical Equipment Operating Expense Total:						**250.00**
Medical Equipment Operating Expense	Months	1	10.00	25.00	**250.00**	
Personal Emergency Response (PERS) - Installation and Testing Total:						**35.00**
Personal Emergency Response (PERS) - Installation and Testing	Event	1	1.00	35.00	**35.00**	
Personal Emergency Response Systems (PERS) Total:						**378.12**
Personal Emergency Response Systems (PERS)	Months	1	12.00	31.51	**378.12**	
Private Duty Nursing - Including Shared Services Total:						**6696489.61**
LVN					**5133147.06**	

GRAND TOTAL:	**9495078.18**
Total Estimated Unduplicated Participants:	**120**
Factor D (Divide total by number of participants):	**79125.65**
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Hours	49	3891.46	26.92		
CHHA	Hours	14	3622.19	18.90	958431.47	
RN	Hours	10	1668.26	36.26	604911.08	
Transitional Case Management Total:						487.20
Transitional Case Management	Hours	1	12.00	40.60	487.20	
			GRAND TOTAL:			9495078.18
			Total Estimated Unduplicated Participants:			120
			Factor D (Divide total by number of participants):			79125.65
			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:						38904.45
Case Management/Coordination	Hours	65	14.05	42.60	38904.45	
Habilitation Services Total:						3068.00
Habilitation Services	Hours	1	100.00	30.68	3068.00	
Home Respite Total:						944.80
Home Respite	Hours	1	40.00	23.62	944.80	
Waiver Personal Care Services (WPCS) and Personal Care Services Total:						2862630.26
Waiver Personal Care Services (WPCS) and Personal Care Services	Hours	54	4754.41	11.15	2862630.26	
Community Transition Services Total:						5000.00
Community Transition Services	Event	1	1.00	5000.00	5000.00	
			GRAND TOTAL:			8992654.57
			Total Estimated Unduplicated Participants:			115
			Factor D (Divide total by number of participants):			78197.00
			Average Length of Stay on the Waiver:			365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations Total:						**5000.00**
Environmental Accessibility Adaptations	Event	1	1.00	5000.00	**5000.00**	
Facility Respite Total:						**1114.50**
Facility Respite	Days	1	5.00	222.90	**1114.50**	
Family/Caregiver Training Total:						**324.80**
Family/Caregiver Training	Hours	1	8.00	40.60	**324.80**	
Medical Equipment Operating Expense Total:						**250.00**
Medical Equipment Operating Expense	Months	1	10.00	25.00	**250.00**	
Personal Emergency Response (PERS) - Installation and Testing Total:						**35.00**
Personal Emergency Response (PERS) - Installation and Testing	Event	1	1.00	35.00	**35.00**	
Personal Emergency Response Systems (PERS) Total:						**378.12**
Personal Emergency Response Systems (PERS)	Months	1	12.00	31.51	**378.12**	
Private Duty Nursing - Including Shared Services Total:						**6074517.43**
LVN	Hours	44	3914.48	26.92	**4636623.27**	
CHHA	Hours	12	3774.99	18.90	**856167.73**	
RN	Hours	10	1604.32	36.26	**581726.43**	
Transitional Case Management Total:						**487.20**
Transitional Case Management	Hours	1	12.00	40.60	**487.20**	
			GRAND TOTAL:			**8992654.57**
			Total Estimated Unduplicated Participants:			**115**
			Factor D (Divide total by number of participants):			**78197.00**
			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:						**32900.41**
Case Management/Coordination	Hours	59	13.09	42.60	**32900.41**	
Habilitation Services Total:						**3068.00**
Habilitation Services	Hours	1	100.00	30.68	**3068.00**	
Home Respite Total:						**944.80**
Home Respite	Hours	1	40.00	23.62	**944.80**	
Waiver Personal Care Services (WPCS) and Personal Care Services Total:						**2994390.93**
Waiver Personal Care Services (WPCS) and Personal Care Services	Hours	53	5067.08	11.15	**2994390.93**	
Community Transition Services Total:						**5000.00**
Community Transition Services	Event	1	1.00	5000.00	**5000.00**	
Environmental Accessibility Adaptations Total:						**5000.00**
Environmental Accessibility Adaptations	Event	1	1.00	5000.00	**5000.00**	
Facility Respite Total:						**1114.50**
Facility Respite	Days	1	5.00	222.90	**1114.50**	
Family/Caregiver Training Total:						**324.80**
Family/Caregiver Training	Hours	1	8.00	40.60	**324.80**	
Medical Equipment Operating Expense Total:						**250.00**
Medical Equipment Operating Expense	Months	1	10.00	25.00	**250.00**	
Personal Emergency Response (PERS) - Installation and Testing Total:						**35.00**
Personal Emergency Response (PERS) - Installation and Testing	Event	1	1.00	35.00	**35.00**	
Personal Emergency Response Systems (PERS) Total:						**378.12**
Personal Emergency Response Systems (PERS)	Months	1	12.00	31.51	**378.12**	
Private Duty Nursing - Including Shared Services Total:						**5511408.14**
LVN					**4134049.48**	

GRAND TOTAL:	**8555301.89**
Total Estimated Unduplicated Participants:	**110**
Factor D (Divide total by number of participants):	**77775.47**
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Hours	39	3937.64	26.92		
CHHA	Hours	11	3934.24	18.90	817928.50	
RN	Hours	10	1542.83	36.26	559430.16	
Transitional Case Management Total:						487.20
Transitional Case Management	Hours	1	12.00	40.60	487.20	
			GRAND TOTAL:			8555301.89
			Total Estimated Unduplicated Participants:			110
			Factor D (Divide total by number of participants):			77775.47
			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:						27545.16
Case Management/Coordination	Hours	53	12.20	42.60	27545.16	
Habilitation Services Total:						3068.00
Habilitation Services	Hours	1	100.00	30.68	3068.00	
Home Respite Total:						944.80
Home Respite	Hours	1	40.00	23.62	944.80	
Waiver Personal Care Services (WPCS) and Personal Care Services Total:						3131099.74
Waiver Personal Care Services (WPCS) and Personal Care Services	Hours	52	5400.31	11.15	3131099.74	
Community Transition Services Total:						5000.00
Community Transition Services	Event	1	1.00	5000.00	5000.00	
			GRAND TOTAL:			8220172.41
			Total Estimated Unduplicated Participants:			106
			Factor D (Divide total by number of participants):			77548.80
			Average Length of Stay on the Waiver:			365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations Total:						**5000.00**
Environmental Accessibility Adaptations	Event	1	1.00	5000.00	**5000.00**	
Facility Respite Total:						**1114.50**
Facility Respite	Days	1	5.00	222.90	**1114.50**	
Family/Caregiver Training Total:						**324.80**
Family/Caregiver Training	Hours	1	8.00	40.60	**324.80**	
Medical Equipment Operating Expense Total:						**250.00**
Medical Equipment Operating Expense	Months	1	10.00	25.00	**250.00**	
Personal Emergency Response (PERS) - Installation and Testing Total:						**35.00**
Personal Emergency Response (PERS) - Installation and Testing	Event	1	1.00	35.00	**35.00**	
Personal Emergency Response Systems (PERS) Total:						**378.12**
Personal Emergency Response Systems (PERS)	Months	1	12.00	31.51	**378.12**	
Private Duty Nursing - Including Shared Services Total:						**5044925.09**
LVN	Hours	35	3960.94	26.92	**3731997.67**	
CHHA	Hours	10	4100.20	18.90	**774937.80**	
RN	Hours	10	1483.70	36.26	**537989.62**	
Transitional Case Management Total:						**487.20**
Transitional Case Management	Hours	1	12.00	40.60	**487.20**	
			GRAND TOTAL:			**8220172.41**
			Total Estimated Unduplicated Participants:			**106**
			Factor D (Divide total by number of participants):			**77548.80**
			Average Length of Stay on the Waiver:			365