

State of California—Health and Human Services Agency  
**Department of Health Care Services**

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NURSING FACILITY/ACUTE HOSPITAL  
TRANSITION AND DIVERSION (NF/AH) WAIVER  
RENEWAL PROPOSAL

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June 10, 2016



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TABLE OF CONTENTS

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**1. NURSING FACILITY / ACUTE HOSPITAL WAIVER RENEWAL.....4**

**2. STAKEHOLDER PROCESS AND FEEDBACK.....5**

**3. WHAT IS STAYING THE SAME.....5**

**4. PROPOSED CHANGES.....7**

**a. CARE MANAGEMENT.....8**

**b. WAIVER CAPACITY AND INSTITUTIONAL TRANSITIONS.....10**

**c. INDIVIDUAL COST LIMIT.....11**

**d. PARTICIPANT RIGHTS.....12**

**e. IN-HOME OPERATIONS WAIVER INTEGRATION AND WAIVER RENAMING.....12**

**f. HOME AND COMMUNITY-BASED SETTINGS.....13**

**5. APPENDICES.....15**

## 1. NURSING FACILITY / ACUTE HOSPITAL (NF/AH) WAIVER RENEWAL:

The Nursing Facility / Acute Hospital (NF/AH) Waiver (Waiver) is intended to allow disabled Medi-Cal members, who would otherwise be institutionalized and reside in a nursing facility or hospital, an opportunity to remain in their own homes and/or community and be independent. It is also an alternative to more costly nursing facility care. Currently there is capacity to serve 3,964 Medi-Cal members under the NF/AH Waiver who vary in acuity and physical and/or mental abilities based on different levels of care (LOC). The NF/AH Waiver will expire December 31, 2016; a renewal submission is due to the Centers for Medicare and Medicaid Services (CMS) in September 2016. The renewed NF/AH Waiver is projected to start January 1, 2017 pending CMS approval. A timeline of completed and proposed renewal activities is available in *Appendix A*.

The following proposal presents the Department of Health Care Services' (DHCS) proposed NF/AH Waiver renewal structure including what will remain the same and what is proposed to change. Throughout the proposal, the following terms and meanings are utilized: **STATE** (DHCS), **PROVIDERS** (organizations, entities and agencies coordinating and / or providing the services to Participants), and **PARTICIPANTS** (individuals enrolled, or who may become enrolled on the NF/AH Waiver, and/or Participants' legal representatives).

The State's primary goal when developing this proposal, was to keep the beneficiary at the center of the decision making process when considering the overall structure of the Waiver; the various components of the Proposal were built around how to provide the best quality of care in a timely manner to current and future Participants while continuing to meet federal requirements.

The State is proposing the following changes to the NF/AH Waiver:

- Implementing local comprehensive care management;
- Moving to an aggregate cost limit and cost neutrality;
- Additional requirements pertaining to ensuring patient and provider safety;
- Modifying the Waiver's financial model;
- Increasing the availability of Waiver providers and services;
- Combining the NF/AH Waiver with the In-Home Operations (IHO) Waiver; and
- Incorporating in Home and Community-Based Settings (HCBS) requirements as set forth by CMS.

During Calendar Year 2018, the State will conduct an interim review of the effectiveness of the these proposed changes to determine if additional slots should continue to be added post 2018 and any modifications should be made.

## **2. STAKEHOLDER AND PARTICIPANT INPUT AND FEEDBACK:**

The State is committed to ongoing stakeholder dialogue throughout the NF/AH Waiver Renewal process with the ultimate goal of identifying the strongest Waiver structure to provide the highest level of quality of care, community integration, independent living, quality of life and availability of providers and services, for Participants. In October 2015, the State initiated a NF/AH Waiver Renewal stakeholder engagement process to seek feedback about the Waiver's current structure. This process included a series of public meetings and workgroups with stakeholders and advocates, providers, community members, and other relevant individuals and entities; and direct input from Participants (Participant interviews and interviews with their circle of support), service providers, and other interested stakeholders. The main challenges with the Waiver that were identified during this process were: 1) Participant health and life experiences, 2) inability to access Waiver services due to being on the NF/AH Waiver waitlist, 3) decreases in authorized services absent a change in a Participant's health status due to annual individual cost limits, and 4) a lack of diverse Waiver providers. The State considered all of these concerns when developing this proposal.

The State is posting this NF/AH Waiver renewal proposal for a formal 30-day public comment period (ending July 10, 2016). The State will also convene five (5) in person meetings throughout the state (Fresno, Los Angeles, Redding, Sacramento and San Diego) during July 2016. DHCS will continue to accept public comments until July 29, 2016. The State will review all comments received through any format and will consider them when working to finalize the Waiver Renewal for submission to CMS in September 2016.

## **3. WHAT IS STAYING THE SAME:**

The State recognizes that there are many aspects of the current NF/AH Waiver that Participants, providers, and advocates value. These components are beneficial to the overall health and welfare of Participants, leading to better outcomes when compared to alternative care options for these same individuals. For these reasons, the Waiver renewal proposal includes no changes to the following components of the current NF/AH Waiver structure:

- Eligibility Criteria;
- Currently Available Services and Provider Types;
- Participant Rights and Safeguards;
- Quality Improvement; and
- Financial Accountability and Model.

For reference, current Waiver language can be found in *Appendix B*.

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NURSING FACILITY/ACUTE HOSPITAL TRANSITION AND DIVERSION  
WAIVER RENEWAL PROPOSAL

---

The State will continue to be responsible for the NF/AH Waiver's overall operations and compliance and will not modify its eligibility criteria for individuals at a skilled nursing LOC. DHCS will continue to require an LOC assessment which verifies eligibility for enrollment into the Waiver program; and a Participants' enrollment will continue to be applied back to the first day of Waiver intake. In addition the State will continue to be responsible for:

- Determining initial Waiver eligibility;
- Monitoring Waiver slots and waitlists;
- Auditing Participant service plans to ensure they are person-centered, and meet Participant needs, preferences, and goals;
- Ensuring appropriate levels of utilization occur;
- Monitoring and overseeing providers and Participants to ensure Medi-Cal rules are being followed;
- Setting the minimum allowable statewide Waiver rates by service; and
- Developing, implementing and directing the Waiver policies and procedures.

Providers will continue to serve the same population group that is served under the current Waiver structure at the frequency, scope and duration that is outlined in the Participant's service plan. The State is not proposing to change the types of services offered or the provider types delivering those services under the Waiver including Waiver Personal Care Services and shared nursing services. Room and board (housing, food, and utility costs) will remain unavailable for payment by Medi-Cal. To ensure Participant health, welfare and informed choice, the State will still require the development of person-centered service plans that meet the needs, goals and preferences of the Participant, and are required to be signed by all appropriate parties. The Participant will remain the primary creator of their service plan and choose and direct their Waiver services as they see fit if they are able to make those decisions. Providers will continue to listen to Participant choices regarding the services they choose and whom they would like to deliver those services. The State will also continue to ensure that Participants receive all services as outlined in their service plan. The continuation of these processes ensures Participants were provided options and Participant choices were informed and person-centered as required by CMS.

By maintaining Participant choice and person-centered planning, the State is also ensuring that Participant rights and safeguards continue. The State will continue to provide a system where Participants are able to send complaints and grievances about their services and/or providers and, in addition, the State will continue to respond to critical events or incidents to assure the health and welfare of Participants. Participants will also maintain the right to appeal decisions that impact their Waiver services and request a State Fair Hearing at any time. Providers will continue to be responsible for addressing any complaints regarding services provided and be required to provide the State with documentation regarding critical events or incidents, provide medication management, and assure the health and welfare of Participants.

The State will sustain all Waiver assurances and measure compliance with these assurances, identify issues, require corrective action and ensure corrections are acted on. The State will continue to analyze and act on trends for system or provider performance, establish priorities and develop strategies for assessing compliance with Waiver requirements, and collect and report on performance measures including compiling information gathered and reporting it publicly and to CMS.

#### **4. PROPOSED CHANGES:**

The State is proposing to restructure the NF/AH Waiver resulting in increases to service delivery, access to providers, and improved health outcomes, for current and future Participants. This includes:

- Localizing care management no sooner than July 1, 2017, which would transition the functions and activities of care management that are currently conducted by the State to contracted care management agencies (CMAs). CMAs would be responsible for identifying available resources at the local level and identifying Medi-Cal members residing in nursing facilities or the hospital for possible enrollment in the Waiver. They would also be responsible for conducting person-centered care management and coordination and reviewing and approving treatment authorizations. Transitioning to this model would provide for comprehensive care management and coordination of timely care for Participants resulting in possible reduced utilization of hospital and long-term nursing home stays. It would also result in additional individuals being moved from institutions to the community. Additional detail for this proposed change can be found in *Section A: Care Management*, below
- Increasing the Waiver size by adding up to 5,000 slots over the term of the Waiver. Increasing the Waiver capacity would reduce the current waitlist, with the goal of eventually eliminating it if possible, and allow for a greater number of eligible Participants to be served. The State is proposing to increase long-term nursing home transitions to the Waiver through use of CMAs, allowing a greater number of eligible Participants access and integration into community settings. Additional detail for this proposed change can be found in *Section B: Waiver Capacity and Institutional Transitions*, below.
- Changing the individual cost limit structure. Currently each Participant is held to an annual individual cost limit which can result in reductions to authorized services even with no change in health status, when service costs increase. This proposal would shift away from an individual per Participant cost limit to a model that calculates cost neutrality in the aggregate. Additional detail for this proposed change can be found in *Section C: Individual Cost Limit*, below.

- Enhancing the health and welfare of Participants and providers by adding provisions to allow for exclusion of Participants who exhibit behavior that poses a threat to others and due process to protect the rights of Participants, providers, and others who are responsible for the care of a Participant. Additional detail for this proposed change can be found in *Section D: Participant Rights*, below.
- Transitioning current Participants of the IHO Waiver to the NF/AH Waiver. This would allow the IHO Participants to utilize the proposed enhanced all-inclusive care management and diverse service provider network implemented under the local care management option of the Renewal. Consolidation of the IHO and NF/AH Waiver gives the State an opportunity to rename the waiver to California’s Home and Community-Based Alternatives Waiver or HCB Alternatives Waiver, for short, which encompasses all the key aspects of the Waiver. Additional detail for this proposed change can be found in *Section E: IHO Waiver Integration and Waiver Renaming*, below.
- Add requirements as set forth by the CMS HCBS final rule. Most services are provided in Participant homes, Congregate Living Health Facilities (CLHF) and Intermediate Care Facilities for the Development Disabilities – Continuous Nursing Care (ICF/DD-CNC) settings fall under new requirements set forth under the HCBS final rule and would need to be evaluated for HCBS setting compliance. Additional detail for this proposed change can be found in *Section F: Home and Community-Based Settings*, below.

## A. CARE MANAGEMENT:

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Appropriate care management is an integral part of a Participant’s ability to integrate and remain successfully independent within the community. The State is proposing structural changes to the NF/AH Waiver that would allow the State to contract with CMAs to facilitate increased care management. CMAs would in turn provide care coordination to Participants and contract with providers for services. Presently, State clinical staff provide care management. By contracting with qualified local CMAs, Participants would receive enhanced person-centered and all-inclusive care management beyond what they receive today. This would include Participant face-to-face assessments; intake activities (including environmental assessments) to determine initial LOC; discussing options in services, service settings and providers with Participants and possible outcomes based on them; assisting Participants when choosing appropriate Waiver services and providers; assessing LOC and medical necessity; connecting Participants with qualified Waiver providers; and identifying and addressing access to care or services issues, if any. Informed decision-making and person-centered care coordination would decrease current high hospital and institutional setting usage; leading to improved health outcomes and the ability for Participants to integrate and remain successfully within the community. It would decrease the length of time that a Participant waits to be approved for the Waiver through increased staffing capacity resulting in Participants accessing needed Waiver services more quickly.

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NURSING FACILITY/ACUTE HOSPITAL TRANSITION AND DIVERSION  
WAIVER RENEWAL PROPOSAL

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The shift to CMAs would likely also result in an increase in both the number of available providers and provider diversity. CMAs would be required to contract with any willing existing NF/AH Waiver provider, but would also bring with them existing provider networks, community experience, disability knowledge, local resources, outreach and awareness and an ability to serve a larger number of Participants with closer interactions and relationships. CMAs would be responsible for utilization management including approval of treatment authorization requests. CMAs would also be responsible for paying providers DHCS established Waiver rates and billing the State's fiscal intermediary in turn for reimbursement. Included below is a description of how the State, Providers and Participants would be impacted by this component of the proposed model.

STATE: Currently, State clinical staff determines LOC assignment, monitor and enforce the individual cost cap, and provide basic care management for Participants. As proposed, State clinical staff would instead determine initial Participant eligibility, complete performance reviews, be responsible for confirming authorization of services from review of all medical documentation (including a signed physician plan) and identified need and track and confirm appropriate actions were taken by CMAs to reduce or resolve issues affecting Participants.

PROVIDERS: As proposed, CMAs would be responsible for providing all-inclusive care management to all Participants. The State would contract with CMAs following an intensive application process. The most qualified CMAs, within geographic regions, which demonstrate the most extensive experience, best knowledge, skills and abilities, and cost-effectiveness, to serve a large number of Participants with a vast array of needs would be chosen. The State would require that interested CMAs:

- Be capable of serving the target population;
- Deliver cost effective services and utilize other funding streams and resources, whenever possible;
- Establish, contract with and maintain a capable provider network at the State established rates, including a requirement to contract with all willing existing NF/AH providers;
- identify Participant health and functional status through care management;
- Track and pay claims and other necessary data to monitor service delivery and Participant health outcomes;
- Maintain a community presence to meet the care and service needs of Participants;
- Are knowledgeable about the skills and abilities of the Waiver population, both current and eligible;
- Provide proof of financial solvency and ongoing viability;
- Have global knowledge regarding the Medi-Cal, Medicare and disability delivery systems; and

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NURSING FACILITY/ACUTE HOSPITAL TRANSITION AND DIVERSION  
WAIVER RENEWAL PROPOSAL

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- Have a Participant or person with a disability serving in an advisory or board member capacity within the CMA.

The State would contract with an adequate number of CMAs to provide statewide coverage and access ensuring local knowledge, presence and the ability to build and sustain a presence for each CMA. CMAs would in turn contract with direct service providers in their approved geographic area to provide direct services to Participants. CMAs would have the ability to authorize medically necessary services based on Participant need. The State will also consider moving the responsibility for Treatment Authorization Requests (TARs) to CMAs. CMAs would perform audits of contracted service providers and report all findings to the State.

PARTICIPANTS: Participants would be assessed by the CMA and assigned a LOC based upon their physical and mental abilities; however the scope, duration, intensity and frequency of services would be approved based on medical need with a physician signed plan of treatment. Changing to a local care management approach would allow Participants to access services from a localized, larger, and more diverse provider network. The network would also provide for more frequent contact with care managers, allowing Participant needs-- including additional services-- to be addressed more quickly. CMAs would have the ability to connect Participants with providers who are trained and knowledgeable about the Participant's individual needs. CMAs would also be accessible to Participants 24 hours a day, seven days a week through member hotlines and/or nurse advice lines.

## B. WAIVER CAPACITY AND INSTITUTIONAL TRANSITIONS:

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The State is proposing to increase the number of Waiver slots by up to 5,000, with the goal of eventually eliminating the current waitlist if possible, and allowing for a greater number of eligible Participants to be served. Currently about 1,800 individuals residing in the community are on the NF/AH Waiver waitlist and wait for a Waiver slot for two to three years. The State is also proposing to establish an enrollment requirement to increase long-term nursing home or hospital transitions so that persons residing in facilities have increased access to live independently and be integrated into the community. Included below is a description of how the State, Providers and Participants would be impacted by this component of the proposed model.

STATE: The State is proposing to increase current Waiver capacity up to an additional 5,000 to 8,964 slots. The State is also setting an enrollment requirement for CMAs of at least six (6) long-term nursing home, hospital or Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) transitions for every four (4) community enrollment, setting a 60 / 40 enrollment benchmark.

PROVIDERS: CMAs would be required to demonstrate in their application that they are adequately staffed and their provider networks are sufficient to handle the expected increase in

enrollment growth, types of enrollment, and Participant needs in order to continue to provide quality care to Participants.

PARTICIPANTS: By increasing the number of Waiver slots, the current waitlist could be phased out over the term of the Waiver, allowing Participants quicker enrollment onto the Waiver and increased access to medically needed services; and allowing individuals to stay in their homes or transition back to the community.

### C. INDIVIDUAL COST LIMIT:

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Currently the Waiver utilizes an individual cost limit for each LOC for Waiver Participant annual services. The State is proposing to change from an individual cost limit to an individual cost limit that calculates cost neutrality in the aggregate across all Waiver Participants. This would allow Participants to receive additional services when medically necessary with no annual cost limit. In addition, the Waiver utilizes eight (8) Participant LOCs, all of which provide a different level of Waiver services. The State is proposing to reduce the number of LOCs from eight (8) to three (3): Nursing Facility A/B, Subacute, and Acute. Doing so would reduce assessor burden and significantly decrease challenges associated with “fitting” a waiver Participant into a myriad of possible LOCs as a determinant of authorized services. As proposed, LOC assignments will no longer be tied to an annual individual cost limit, rather they will be used for identification and tracking purposes when monitoring Waiver activities. Included below is a description of how the State, Providers and Participants would be impacted by this component of the proposed model.

STATE: The State would shift from an annual individual cost limit for Waiver participants to calculating cost neutrality in the aggregate for all Participants. The State will institute monitoring procedures and frequent checks and balances to ensure management of medically necessary services and cost neutrality are appropriately occurring.

PROVIDERS: Three (3) identified LOCs would allow for greater flexibility, be used as functional guidelines, and include broader definitions when determining a Participant’s LOC. Assessors find it difficult to fit a Participant into an identified LOC; reducing the number of unnecessary LOCs allows for a clearer understanding and application of the LOC assignment. CMAs would be able to authorize services that showed a justified medical need and a signed physician Plan of Treatment, as approved by the Department.

PARTICIPANTS: Three (3) LOCs would allow Participants to identify with a LOC but not be forced to fit into rigid definition of the current more narrow LOCs. LOCs would no longer be used to set parameters around spending but would be used for tracking and identification, resulting in the calculation of data points and/or metrics which will assess NF/AH Waiver population acuity and physical or mental ability levels. Participants would be able to receive services based on medical

need and not have to reduce or modify the scope, duration or frequency of Waiver services because the unit cost of a service has increased.

#### D. PARTICIPANT RIGHTS:

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The State is proposing a change to the Participants Rights section of the current Waiver to help ensure the overall safety of Participants, and their caregivers, service providers, and care managers. The State would send a Notice of Action terminating the Participant from enrollment in the Waiver when a Participant is found to be a threat or harm to others they are residing with, caregivers or service providers, care managers or the community at large; or are unable to safely integrate into social settings to ensure the health and safety of the circle of support around the Participant. This will also help ensure Participant ability to be integrated in social settings and the community appropriately. Included below is a description of how the State, Providers and Participants would be impacted by this component of the proposed model.

STATE: The State would send a Notice of Action when a Participant is a threat or harm to others in the specified circumstances. This would mean the Participant would be ineligible for entrance or continued enrollment in the Waiver and would require that the provider make a referral to a more appropriate setting for the Participants' medically necessary services.

PROVIDERS: Service providers and caregivers employed by licensed settings are required to plan and prepare for challenging behaviors of Participants and situations. The ability to request a Notice of Action when a Participant's roommates, circle of support, or providers are at risk of being harmed by the Participant will allow all persons to remain or work in a safe environment.

PARTICIPANTS: All Participants would continue to have the right to a State Fair Hearing after being sent a Notice of Action and to request aid paid pending, these rights would not change.

#### E. IHO WAIVER INTEGRATION AND WAIVER RENAMING:

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New changes being proposed for the NF/AH waiver align with the structure of the current IHO Waiver. Due to this alignment, the State believes that it would be beneficial to combine the NF/AH and IHO waivers under the renewal. This would provide IHO Waiver Participants access to comprehensive care management which is not currently available at the level which the State is proposing for the NF/AH Waiver, and reduce administrative burden to the State. As a part of integration, the State proposes to rename the NF/AH Waiver to HCB Alternatives Waiver. The new waiver name highlights all the key aspects and opportunities of integrating the IHO and NF/AH Waivers. Included below is a description of how the State, Providers and Participants would be impacted by this component of the proposed model.

STATE: The State would seamlessly transition all Participants who are currently on the IHO Waiver to the NF/AH Waiver. These individuals would experience no change in services due to

the integration of the waivers. The State would protect the safety and well-being of IHO Participants during all transitions to the CMAs and confirm continued receipt of their medically needed services. By renaming the NF/AH to a more easily recognized and remembered name, the State anticipates an increase in public awareness and opportunity to refer and utilize the Waiver from various settings.

PROVIDERS: CMAs would confirm that Participants shifting from the IHO Waiver experience no change and continue receiving all medically needed services; continuity of care for existing providers would occur. CMAs and direct service providers can refer to the consolidated waiver under its new Waiver name and not have confusion between Participants enrolled in the old IHO or NF/AH Waivers.

PARTICIPANTS: Current IHO Participants would be assigned to a CMA that would offer the same level of benefits and opportunities that are available to them today in addition to the benefit that CMAs can offer under the new NF/AH Waiver construct. The new Waiver name is expected to reduce confusion, build awareness and increase access to in-home and community-based care for all eligible persons.

## F. HOME AND COMMUNITY-BASED SETTINGS:

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As a part of the renewal, the State is proposing to ensure that home settings, including CLHFs and ICF/DD-CNCs, meet new federal regulations. Many Participants reside in their own private dwellings and the State presumes that these homes meet the characteristics of home and community-based settings requirements. Other Participants may choose to reside in an alternative residential setting such as CLHFs and ICF/DD-CNCs. Services that are provided to Participants in these settings are included in their person-centered care plan with the intention of maintaining individuals in the community.

CMAs will be responsible for ensuring Participant privacy and autonomy is respected in these settings. In provider owned or controlled settings, the CMA team must determine that the setting is appropriate to the Participant's need for independence, choice and community integration. The person-centered process is always used to choose the services and settings and determine if the setting is appropriate to meet the Participant's needs and choices. Provider owned or controlled residential settings would take into consideration the following characteristics, as specified by federal law and guidance:

1. Private or semi-private bedrooms shared by no more than two persons, with choice of roommate, decorated with personal items. Private or semi-private bathrooms. The Participant must have enough bathroom space to ensure privacy for personal hygiene, dressing, etc.
2. Common living areas or shared common space for interaction between Participants, and their guests.
3. Participants must have access to a kitchen area at all times.

4. Participants' opportunity to make decisions on their day-to-day activities, including visitors and when and what to eat, in their home and in the community.
5. Services which meet the needs of each Participant.
6. Assurance of Participant rights: a) to be treated with respect; b) choose and wear their own clothes; c) have private space to store personal items; d) have private space to visit with friends and family; e) use the telephone with privacy; f) choose how and with whom to spend free time; and g) Participants can schedule and take part in community activities of their choice; h) residential units are accessible to the Participant and have lockable entrance doors with appropriate staff having keys; and i) entering into tenant rights agreements under landlord tenant law of the State, county, city or other designated entity.

Congregate Living Health Facility: CLHF's are residential facilities with a non-institutional, homelike environment and are an alternative setting for Participants that require institutional level of care but choose to receive their medical services in a home or community setting. CLHF's provide inpatient care that includes the following array of services: medical supervisions, 24-hour skilled nursing services and supportive care, pharmacy, dietary, social, recreational and services for Participants who meet the LOC criteria and are Participants whose medical condition(s) are within the scope of licensure for a CLHF. Participants have freedom of choice to accept or refuse this setting as their residence.

Intermediate Care Facilities for the Developmentally Disabled-Continuous Nursing Care: ICF/DD-CNC's are residential facilities that are an alternative setting for developmentally disabled individuals that require an institutional level of care but choose to receive their medical services in this setting. An ICF/DD-CNC specializes in the unique needs of the developmentally disabled Participant. ICF/DD-CNC's provide inpatient care that includes the following array of services: medical supervision, 24-hour skilled nursing services and supportive care including pharmacy, dietary, social, recreational and other services for Participants who meet the LOC criteria of the Waiver and need the availability of skilled nursing care on a continuous basis. Participants have freedom of choice to accept or refuse this as their residential setting.

The Waiver transition plan is incorporated in the statewide transition plan with more detail shown in *Appendix: C*. Included below is a description of how the State, Providers and Participants would be impacted by this component of the proposed model.

STATE: The State would presume all privately owned residences comply with the HCBS federal rule. The State would, however, require CMAs to perform a home evaluation to ensure that residences are in continued compliance. For non-private residences, the State would ensure these facilities are compliant by performing on site visits prior to approval as a Waiver provider, and with ongoing annual visits. The federal government requires that facilities which function more like an institution (e.g., ICF/DDs) are not home and community-based approved settings, therefore the State will transition ICF/DD-CNC facilities to the Medi-Cal State Plan as long-term care facilities or providers.

PROVIDERS: CMAs would be responsible for ensuring that private residences of Participants are in compliance with federal requirements. CMAs would perform home evaluations during the initial face-to-face assessment and bi-annual reassessments. CLHFs would be required to make the necessary changes to meet the HCBS requirements to continue as a Waiver provider. ICF/DD-CNCs would experience a smooth transition under a State Plan Amendment adding ICF/DD-CNCs as a long-term care provider type.

PARTICIPANTS: Participants who reside in their own home will not be affected by the HCBS requirements if their private home complies with the main characteristics of the HCBS requirements. Participants residing within CLHFs would only be affected if the facility they reside in is not able to meet HCBS requirements and refused to go through the heightened scrutiny process. If there is a need for a Participant to relocate, the State will work closely with the CMA to ensure that a smooth transition takes place and Participant needs and continuity of care are met to ensure no gaps in care occur. Participants residing in ICF/DD-CNCs will be given the opportunity to move to an HCBS compliant setting to continue receiving waiver services and will also have the opportunity to remain at the ICF/DD-CNC, if they choose to continue living there.

## **5. APPENDICES**

- A. Timeline of Renewal Activities
- B. Current NF/AH Waiver
- C. NF/AH Waiver Portion of the Statewide Transition Plan