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.

RENEWAL

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Significant changes to this waiver renewal include:

- Addition of Personal Care as a waiver benefit
- Addition of LCSW classification as a care coordinator
- Addition of ACSW classification as a family counselor (part of Amendment 3)
- Change to full F-CAP review schedule (from 60 days to six months)
- Rewording of performance measures to better capture appropriate data (Appendix A, B, D & G)
- Rewrite of Appendix H to better define processes for trending, monitoring and implementing system improvements

State:	
Effective Date	

1. Request Information

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

B. Waiver Title (*optional*): Pediatric Palliative Care Waiver

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

○	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
X	**Renewal (5 Years) of Waiver #**	CA.03.01.00	
○	**Amendment to Waiver #**		

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

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

E.1 Proposed Effective Date: 04/01/12

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

X	Hospital *(select applicable level of care)*	
	X	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	○	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
☐	Nursing Facility *(select applicable level of care)*	
	○	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:

	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☐	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

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

☐	Services furnished under the provisions of §1915(a)(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)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§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:*			
X	Not applicable			

H. **Dual Eligibility for Medicaid and Medicare.** Check if applicable:
X This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

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

The purpose of this waiver is to provide pediatric palliative care services to allow children who have a California Children's Services (CCS)-eligible medical condition with a complex set of needs and their families the benefits of hospice-like services, in addition to state plan services during the course of an illness, even if the child does not have a life expectancy of six months or less. This waiver is authorized under Welfare and Institutions Code §14132.74. The waiver is based on the principle that if curative treatment is provided along with palliative care, there can be an effective continuum of care throughout the course of the medical condition. The objective is to minimize the use of institutions, especially hospitals, and improve the quality of life for the participant and Family Unit (siblings, parent/legal guardian, and others living in the residence).

Services provided through the waiver include:

- Comprehensive care coordination
- Respite care
- Family counseling (for members of the Family Unit and other primary caregivers, as applicable)
- Expressive therapies (art, music, massage, Child Life)
- Family training (including but not limited to: education and instruction on palliative care principles, care needs, treatment regimens, and use of equipment)
- Pain and symptom management
- Personal care

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)*:

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

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

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

H. Quality Improvement Strategy. **Appendix H** contains the overall systems improvement 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)*:

○	Yes
X	No
○	Not applicable

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

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

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

X	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. S*pecify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
	The following California counties currently participate in the waiver: Alameda, Fresno, Los Angeles, Marin, Monterey, Orange, San Diego, San Francisco, Santa Clara, Santa Cruz and Sonoma. Future participating counties may include: Kern, San Bernardino, Riverside, Humboldt, and Sacramento.
☐	**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 Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and,

(2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

***Note**: Item 6-I must be completed.*

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

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

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

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

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

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

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §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 throughout the application and in **Appendix H**.

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

Between November 29, 2006 and May 1, 2008, DHCS held a series of meetings with stakeholders for the purpose of obtaining input for the development and implementation of a pediatric palliative care waiver. Many of the participants were invited because of their expertise in the field of pediatric palliative care. Stakeholders included physicians (pediatricians and pediatric specialists), representatives from CCS tertiary hospitals and special care centers (SCCs), nurses, social workers, hospice agencies, hospice/palliative care coalitions and associations, home health agencies, parents of children with special healthcare needs, as well as DHCS and County CCS staff.

Stakeholders were briefed on Medicaid rules, cost neutrality expectations, enabling legislation, current limitations on state plan services and opportunities provided by the waiver process. The group was briefed, as well, on roles of Federal CMS, *State CMS*, and the stakeholder groups in the waiver development process.

Stakeholders divided into three subcommittees and met several times to develop criteria for waiver eligibility, define the scope of service delivery, and identify data outcome measures for evaluation purposes. The stakeholders will be included in the information exchange throughout the waiver development process.

Since the waiver was approved DHCS has started holding quarterly meetings with PFC provider agencies and other stakeholders to discuss utilization of existing PFC services, and the provider qualifications outlined in the current waiver. These discussions have also addressed considerations of modifications to services,

additional services that would support PFC clients while fitting within agency scope, and modifications to provider qualifications based on providers who currently provide these services to clients in other programs. Family/Participant input received during the 60-day Family-Centered Team meetings (members include Care Coordinator, participant/family, CCSNL, other providers as available) is shared with the State during quarterly phone calls as well as being part of the service plan, called the Family-Centered Action Plan (F-CAP) in this waiver.

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

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 – August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

First Name:	Jill
Last Name	Abramson, M.D., M.P.H.
Title:	Medical Policy and Consultation Section Chief, Children's Medical Services
Agency:	Systems of Care Division, Department of Health Care Services
Address 1:	1515 K. Street, Room 400
Address 2:	
City	Sacramento
State	CA
Zip Code	95814
Telephone:	916-327-2108
E-mail	Jill.Abramson@dhcs.ca.gov
Fax Number	916-327-1123

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

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

8. Authorizing Signature

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

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

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	Douglas
Last Name	Toby
Title:	Director
Agency:	California Department of Health Care Services
Address 1:	P.O. Box 997413, MS 0000
Address 2:	
City	Sacramento
State	California
Zip Code	95899-7413
Telephone:	
E-mail	
Fax Number	

Attachment #1

Transition Plan

Specify the transition plan for the waiver:

The Federal government authorized the "Medicaid 1915(c) Home and Community-Based Services (HCBS) Waiver program" in 1981 under Section 2176 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35). It is codified in section 1915(c) of the Social Security Act. The original legislative intent of the HCBS Waiver program was to slow the growth of Medicaid (Medi-Cal in California) spending by providing services in less expensive settings. In order to contain costs, the federal legislation limited waiver services to individuals who would be institutionalized if the services were not provided. However, the costs of those waiver services cannot be higher than what they would cost in an institutional setting.

The law permitted states to waive certain Medicaid program requirements and in doing so, deviate from Medicaid requirements, such as providing services only in certain geographic areas ("waive statewideness"). The HCBS Waiver program also allowed states flexibility to offer different types of services to individuals with chronic disabilities. Prior to this, with the origin of Medicaid in 1965, Beneficiaries could only receive comprehensive long-term care in institutional settings ("budget neutrality").

The initial waiver application is approved by the Centers for Medicare & Medicaid Services (CMS) for three (3) years with additional renewal applications needing to be approved every five (5) years. The waiver can be designed for a variety of targeted diagnosis-based groups including individuals who are elderly, and those who have physical, developmental, or mental health disabilities, or other chronic conditions such as Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS). The waiver can be designed to offer a variety of services including case management, personal attendant services, adult day health care services, habilitation services, day treatment services, psychosocial rehabilitation services, mental health services, and other services specifically requested by the State. The 1915(c) HCBS waivers have subsequently become mechanisms for many states, including California, to provide Medicaid-funded community-based, long-term care services and supports to eligible Beneficiaries.

Background – 1915(i) State Plan

The Deficit Reduction Act of 2005 (DRA) gave states starting January 1, 2007 a new option to provide HCBS through a state plan amendment (SPA). Once approved by CMS, 1915(i) SPAs do not need to be renewed nor are they subject to some of the same requirements of waivers; for example, budget neutrality. Under this option, states set their own eligibility or needs-based criteria for providing HCBS. States are allowed to establish functional criteria in relation to certain services. The DRA provision eliminated the skilled need requirement and allowed states to cover Medicaid

Beneficiaries who have incomes no greater than 150 percent of the federal poverty level and who satisfy the needs-based criteria. The Patient Protection and Affordable Care Act of 2010 created several amendments including elimination of enrollment ceilings, a requirement that services must be provided statewide, and other enrollment changes.

In early January 2014, CMS announced it had finalized important rules that affect HCBS provided through Medicaid/Medi-Cal, and subsequently published the regulations in the Federal Register on January 16, 2014. The rules became effective 60 days from publication, or March 17, 2014. These regulations are CMS 2249-F and CMS 2296-F.

Overview of State Responsibility for the Partners for Children Pediatric Palliative Care Medicaid 1915(c) Waiver

The State's HCBS program administrative teams are comprised of employees from the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), the Department of Developmental Services (DDS), and the California Department of Aging (CDA). The San Francisco Department of Public Health (SFDPH) administers a 1915(c) waiver in accordance with terms of an Agreement with DHCS.

***Partners for Children Pediatric Palliative Care* Medicaid 1915(c) Waiver**
This waiver offers children with life limiting conditions a range of home-based hospice-like services while they maintain the option of receiving curative treatment. According to diagnosed need and an approved plan of care, services include: care coordination, expressive therapies, family training, individual and family caregiver counseling/bereavement services, pain and symptom management, personal care and respite care.

PPC Waiver provider types include all of the following:

- Agency Certified Nursing Assistant
- Art Therapist
- Associate Clinical Social Worker
- Child Life Specialist
- Congregate Living Health Facility
- Home Health Agency
- Home Health Aide
- Hospice Agency
- Licensed Clinical Social Worker
- Licensed Psychologist
- LVN
- Marriage and Family Therapist (requested to be included as a provider type)
- Masters Level Social Worker
- Massage Therapist
- Music Therapist
- RN

Corresponding State Administrative Team for the Partners for Children Pediatric Palliative Care Medicaid 1915 (c)PPC Waiver (0486): DHCS, Systems of Care Division

Partners for Children Pediatric Palliative Care 1915(c) Waiver Program Compliance with Final Rule Requirements Pertaining to HCB Settings

1. **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**

   The Partners for Children (PFC) pediatric palliative care waiver program is in full compliance with the final rule requirement pertaining to the need to be fully integrated in, and to support access to, the greater community. As is consistent with State and Federal law, when medical and supportive services are provided to a minor child, the Beneficiary's Parent(s)/Legal Guardian may exercise the Beneficiary's rights when the Beneficiary is unable to do so.

   The purpose of the PFC program is to provide a coordinated system of home-and community-based care that improves the quality of life for Beneficiaries (children/youth up to 21 years) and the Family Unit (Parents, Legal Guardians and significant others), and minimizes the use of institutions, particularly acute care hospitals, to treat life-threatening medical conditions. Program services are provided to the child/youth and Family Unit by home health care or hospice agencies, in coordination with the California Children's Services (CCS) program of the Department of Health Care Services (DHCS), and the Primary Physician Provider. Home health/hospice agency staff work in cooperation with the Beneficiary and the Parent(s)/Legal Guardian to coordinate all aspects of care, including PFC program services, State plan services, and community resources.

   Upon enrollment in the PFC program, the Beneficiary and the Parent(s)/Legal Guardian choose a home health care or hospice agency service provider, as well as a Care Coordinator employed by the home health/hospice agency. A critical part of the PFC program family-centered process is to incorporate disease and pain management, and community supports to meet the physical, emotional, cultural, spiritual, and psychosocial needs of children and families who live with life-threatening medical conditions. The child/youth and his/her Parent(s)/Legal Guardian are encouraged to invite individuals of their choice, referred to as a "Circle of Support", to actively participate in the development of the Family-Centered Action Plan, also known as the "F-CAP". In this manner, the Beneficiary and the Family Unit receive support from a coordinated community-based network which may include: school nurses, counselors, teachers, classmates, teammates, and friends, as well as medical care providers and religious/spiritual advisors.

The Beneficiary and the Parent(s)/Legal Guardian actively direct the care planning process, including the implementation of changes in care¸ and are advised, in writing, of their right to do so. In addition to comprehensive care coordination, home and community-based services provided through the PFC pediatric palliative care program include: pain and symptom management; expressive therapies to assist the Beneficiary and siblings in creatively communicating their understanding and reaction to dealing with a life-threatening illness; in-home and out-of-home respite care; family training related to care needs, treatment regimens, and use of medical equipment; and bereavement and grief counseling.

2. **Giving individuals the right to select from among various setting options, including non-disability specific settings and an option for a private unit in a residential setting**

The PFC pediatric palliative care waiver program is in full compliance with the final rule requirement pertaining to the right to select from among various setting options, including a private unit in a residential setting. As is consistent with State and Federal law, when medical and supportive services are provided to a minor child, the Beneficiary's Parent(s)/Legal Guardian may exercise the Beneficiary's rights when the Beneficiary is unable to do so.

Children/youth with life-threatening medical conditions cannot be enrolled in the PFC program without Parent(s)/Legal Guardian approval/consent. Once program eligibility is determined, the CCS Nurse Liaison reviews the PFC program with the Parent(s)/Legal Guardian. The child's/youth's enrollment is not finalized without the signed consent of the Parent(s)/Legal Guardian on the "Partners for Children Freedom of Choice" and the "Partners for Children Participant Enrollment" forms. (Please refer to attached forms.)

Upon enrollment in the PFC program, the child/youth and the Parent(s)/Legal Guardian have the option of choosing among available home health care/hospice providers, and also may choose an agency staff member to serve as their Care Coordinator. The PFC Care Coordinator continually assesses the home environment to ensure that safe and professional pediatric palliative care can be provided at the level of intensity needed to meet the Beneficiary's and Family Unit's unique physical, emotional, cultural, spiritual, and psychosocial needs. This home environment assessment includes: evaluating whether patient care areas can adequately accommodate and facilitate all that is needed to provide safe and comfortable home-based care. This includes the use, maintenance, and cleaning of all medical devices, equipment, and stored supplies.

3. **Ensuring individual's rights to privacy, dignity, respect, and freedom from coercion or restraint.**

   The PFC pediatric palliative care waiver program is in full compliance with the final rule requirement pertaining to ensuring the Beneficiary's and Family Unit's rights to privacy, dignity, respect, and freedom from coercion or restraint. As is consistent with State and Federal law, when medical and supportive services are provided to a minor child, the patient's Parent(s)/Legal Guardian may exercise the Beneficiary's rights when the Beneficiary is unable to do so.

   The initial and ongoing home environment assessment, conducted by the PFC Care Coordinator, ensures that the patient care areas adequately accommodate and facilitate all that is needed to provide safe and comfortable home-based care. This includes the use, maintenance, and cleaning of all medical devices, equipment, and stored supplies. Home health care/hospice agency staff also is responsible for ensuring that: medical equipment is in working order at all times; safety and preventative measures are in place; and that all supportive services are in place prior to the start of care. This includes training caregivers to support the care of the Beneficiary, and maintaining verification of such training in the Beneficiary's PFC case file.

   The Care Coordinator notifies Beneficiaries and families of their rights and obligations, in writing, before care begins. In addition, the Beneficiary and the Parent(s)/Legal Guardian actively steer the care planning process, including the implementation of changes in care, and are advised, in writing, of their right to do so.

   All PFC providers are required to have policies and procedures in place, to fully comply with State law and the Health Insurance Portability and Accountability Act (HIPAA) requirements regarding privacy and security of Protected Health Information (PHI) for Medi-Cal clients. At the time of enrollment in the CCS program, Beneficiaries and their Parent(s)/Legal Guardians are advised of their rights to: voice complaints and suggest changes in services and staff without fear of discrimination, reprisal or restraint for having done so; and their right to resolve grievances through the State fair hearing process.

4. **Optimizing autonomy and independence in making life choices, including daily activities, physical environment, and with whom to interact**

   The PFC palliative care waiver program is in full compliance with the final rule requirements pertaining to the need to optimize patient/family autonomy and independence in making life choices, including daily activities, physical environment, and with whom to interact. As is consistent with State and Federal law, when medical and supportive services are provided to a minor child, the Beneficiary's Parent(s)/Legal Guardian may exercise the Beneficiary's rights when the Beneficiary is unable to do so.

A critical part of the PFC program family-centered process is to incorporate disease and pain management, and community supports, to support the physical, emotional, cultural, spiritual, and psychosocial needs of children and families who live with life-threatening medical conditions. The child and his/her Parent(s)/Legal Guardian are encouraged to invite individuals of their choice, referred to as a "Circle of Support", to actively participate in the development of the Family-Centered Action Plan, also known as the F-CAP. In this manner, the PFC program encompasses the child/youth and the Family Unit with a coordinated network of support. The Family Unit's designated support network may include school nurses, counselors, teachers, classmates, teammates, and friends, as well as medical care providers and religious/spiritual advisors.

The following home and community-based services are implemented and scheduled based upon the family preferences and time constraints:

- Comprehensive care coordination;
- In-home respite care, as well as out-of-home respite care;
- Expressive therapies;
- Family therapy and family education;
- Pain and symptom management;
- Personal care; and
- Family bereavement and grief counseling.

The PFC program agency staff work with the Beneficiary/Family Unit to facilitate access to care. The Beneficiary's/Family Unit's goals and objectives are met through shared decision-making and a holistic approach to service recommendations and integration.

5. Facilitating choice regarding services and supports, and who provides them

The PFC pediatric palliative care waiver program is in full compliance with the final rule requirement pertaining to the need to facilitate and coordinate program services and supports, and who provides them. As is consistent with State and Federal law, when medical and supportive services are provided to a minor child, the Beneficiary's Parent(s)/Legal Guardian may exercise the Beneficiary's rights when the Beneficiary is unable to do so.

When eligibility is determined, the CCS Nurse Liaison meets with the family to review the PFC program in greater detail. It is the family's choice whether or not to enroll in the PFC program. It also is the family's right to choose among available home health agency/hospice providers. Families that wish to enroll in the PFC program must sign a "Participant Agreement Form" acknowledging they understand their rights and responsibilities, and agree to work with their PFC agency to determine which palliative care services and community supports best meet their needs.

The Care Coordinator is trained to use collaborative communication techniques to assist Beneficiaries and families in establishing goals of care that support their physical, emotional, cultural, spiritual, and psychosocial needs. The Care Coordinator meets with the family to complete the Family-Centered Action Plan, also known as the "F-CAP", which identifies the needs, goals and community-based services to be provided through PFC and Medi-Cal. The family-driven F-CAP is continually revised, as changes in care become necessary.

In addition to comprehensive care coordination, services provided through the PFC pediatric palliative care waiver program include: pain and symptom management; expressive therapies to assist the Beneficiary in creatively communicating his/her understanding and reaction to dealing with a life-threatening illness; in-home and out-of-home respite care; family training related to care needs, treatment regimens, and use of equipment; and bereavement and grief counseling.

For Medi-Cal Provider-owned or controlled HCB settings, the Provider must offer the following (bulleted and in bold):

1. **A legally enforceable agreement between the Provider and the consumer that allows the consumer to own, rent or occupy the residence and provides protection against eviction**

   At this time, only one Medi-Cal Provider-owned or controlled HCB setting, George Marks Children's House, is approved to provide out of home respite, a PFC pediatric palliative care program service. As is consistent with State and Federal law, when medical and supportive services are provided to a minor child, the Beneficiary's Parent(s)/Legal Guardian may exercise the Beneficiary's rights when the Beneficiary is unable to do so.

   It is our understanding that George Marks Children's House is in compliance with the final rule requirement pertaining to having a legally enforceable agreement between the Provider and the Beneficiary's Parent(s)/Legal Guardian.

2. **Privacy in units including lockable doors, choice of roommates and freedom to furnish and decorate units; Options for individuals to control their own schedules including access to food at any time**

   At this time, only one Medi-Cal Provider-owned or controlled HCB setting, George Marks Children's House, is approved to provide out of home respite, a PFC pediatric palliative care program service. As is consistent with State and Federal law, when medical and supportive services are provided to a minor child, the Beneficiary's Parent(s)/Legal Guardian may exercise the Beneficiary's rights when the Beneficiary is unable to do so.

It is our understanding that George Mark Children's House is in compliance with the final rule requirement pertaining to: privacy; choice of roommates; freedom to furnish and decorate units; and providing options for the Beneficiary and the Parent(s)/Legal Guardian to exert control over the Beneficiary's schedule.

3. Individuals the freedom to have visitors at any time

At this time, only one Medi-Cal Provider-owned or controlled HCB setting, George Marks Children's House, is approved to provide out of home respite, a PFC pediatric palliative care program service. As is consistent with State and Federal law, when medical and supportive services are provided to a minor child, the Beneficiary's Parent(s)/Legal Guardian may exercise the Beneficiary's rights when the Beneficiary is unable to do so.

It is our understanding that the George Mark Children's House is in compliance with the final rule requirement pertaining to providing the Beneficiary and the Parent(s)/Legal Guardian with freedom to have visitors.

4. A physically accessible setting

At this time, only one Medi-Cal Provider-owned or controlled HCB setting, George Marks Children's House, is approved to provide out of home respite, a PFC pediatric palliative care program service. As is consistent with State and Federal law, when medical and supportive services are provided to a minor child, the Beneficiary's Parent(s)/Legal Guardian may exercise the Beneficiary's rights when the Beneficiary is unable to do so.

It is our understanding that the George Mark Children's House is in compliance with the final rule requirement pertaining to maintaining a physically accessible setting.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

X	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one)*		
	X	The Medical Assistance Unit *(name of unit) (do not complete Item A-2*):	Systems of Care Division, Children's Medical Services, Medical Policy and Consultation Section
	○	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit). 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. 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).*		

2. 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.

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:

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

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

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

X	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
	In accordance with 22 CCR, §51013, the California Children's Services (CCS) program provides utilization management and authorization of services for children with special health care needs. The CCS programs are run at the county level for independent counties and at regional offices for dependent counties. *State CMS* is the DHCS designated agency responsible for administration and oversight of the CCS program and is the acting Medicaid agency providing oversight for this waiver. The relationship between the county CCS program and *State CMS* is described in Health and Safety Code (H&S Code), §123850 as a joint partnership.
☐	**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*:
☐	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

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

State CMS is responsible for assessing the performance of participating county CCS programs serving waiver children residing in those counties. AB 1745, Chapter 330, 2006 of the Welfare and Institutions (W&I) Code, §14132.74 is the enabling legislation for California's PFC Waiver. Waiver sites were established in 11 counties within the state during the first waiver period. An additional 14 counties may be eligible to participate during the renewal period.

Children's Medical Services is a part of the Department of Health Care Services charged with oversight of the California Children's Services (CCS) program. See regulations: CCR Title 22 §51013; H&S Code §§123800, 123805, 123810, 123822, 123845, 123850, 123995; W&I Code §§10720, 10725, 14100.1, 14124.5, 14000.03, 14131, 14133.

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:

State CMS staff continuously monitor the waiver utilization management and service authorization activities of the participating County CCS programs. This monitoring is done on an ongoing basis in the form of review of HCBS waiver assurances:

- Level of Care
- Service Plan
- Qualified Providers
- Health and Welfare
- Administrative Authority
- Financial Accountability

State CMS monitors the participating county CCS programs through ongoing:

- Examination of current files/data in CMSNet (CCS case management database/network)
- Examination of submitted forms
- Examination of authorized services in CMSNet
- Review of data in PFC access database
- Review of policies and procedures
- Interviews with the county program CCS Nurse Liaison (CCSNL) and medical consultant
- Review of paid claims data in the Medi-Cal Fiscal Intermediary (FI) database
- Monthly teleconference with all participating counties

State CMS obtains feedback on satisfaction with the county CCS program from families, waiver providers, and referring CCS providers.

6. **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 an administrative 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	Local Non-State Entity
Participant waiver enrollment	X	X
Waiver enrollment managed against approved limits	X	X
Waiver expenditures managed against approved levels	X	☐
Level of care evaluation	X	X
Review of Participant service plans	X	X
Prior authorization of waiver services	X	X
Utilization management	X	X
Qualified provider enrollment	X	X
Execution of Medicaid provider agreements	X	☐
Establishment of a statewide rate methodology	X	☐
Rules, policies, procedures and information development governing the waiver program	X	☐
Quality assurance and quality improvement activities	X	X

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.

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

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

Performance Measure: **ADMINISTRATIVE ~oversight meetings**	**Dates, topic(s), and attendees of Medicaid oversight meetings with State DHCS staff, local/regional non-state agencies, and waiver providers to measure active participation by all necessary attendees during the review of policy compliance**		
Data Source [e.g. – examples cited in IPG]	***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)*
Meeting Minutes	**X** *State Medicaid Agency*	☐ *Weekly*	**X** *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		X *Continuously and*	☐ *Stratified:*

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		Ongoing	*Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
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)*	
	X *State Medicaid Agency*	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	**X** *Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Performance Measure: **ADMIN ~remediation actions (1)**	**Number and percent of remediation actions that occurred as specified by the Medicaid Agency** Numerator: number of actions occurring as specified Denominator: total number of actions required		
Data Source [e.g. – examples cited in IPG]	***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)*
-Meeting Minutes	**X** *State Medicaid Agency*	*☐ Weekly*	**X** *100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	X *Sub-State Entity*	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X *Continuously and Ongoing*	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other:

			Describe
Data Source 2 [e.g. – examples cited in IPG]	***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)*
-Analyzed collected data	**X** *State Medicaid Agency*	☐ *Weekly*	**X** *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Source 3 [e.g. – examples cited in IPG]	***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)*
-On-site observations, interviews, monitoring	**X** *State Medicaid Agency*	☐ *Weekly*	**X** *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

State:	
Effective Date	

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)*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure: **ADMIN ~remediation actions (2)**	**Number and percent of remediation actions that occurred within the timeframe as specified by the Medicaid Agency** Numerator: number of actions occurring within the timeframe Denominator: total number of actions		
Data Source 1 [e.g. – examples cited in IPG]	***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)*
-Meeting Minutes	**X** *State Medicaid Agency*	☐ *Weekly*	**X** *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Data Source 2 [e.g. – examples cited in IPG]	***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)*
-Analyzed collected data	**X** *State Medicaid Agency*	☐ *Weekly*	**X** *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	
		X *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Source 3 [e.g. – examples cited in IPG]	***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)*
-On-site observations, interviews, monitoring	**X** *State Medicaid Agency*	☐ *Weekly*	**X** *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

State:	
Effective Date	

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)*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure: **ADMIN ~county oversight**	**Number and percent of F-CAPs with authorization(s) matching for requested services in type, amount, frequency and duration.** Numerator: number of F-CAPs with matching authorization(s) Denominator: a representative sample of F-CAPs		
Data Source [e.g. – examples cited in IPG]	***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)*
Record review - off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	95%
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
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:	
Effective Date	

	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure: **ADMIN ~LOC evaluation oversight**	**Number and percent of LOC evaluations that were completed according to policy by the CCSNL.** Numerator: number of LOC evaluations that are consistent with policy Denominator: a representative sample of LOCs		
Data Source [e.g. – examples cited in IPG]	***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)*
Record review - off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	95%
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
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)*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	

	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

a.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

b.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.*

State CMS provides ongoing monitoring of the waiver utilization management and service authorization activities of participating County CCS programs specifically to review waiver assurances.

Upon discovery, *State CMS*, within 15 working days, contacts the participating county(s) to:

1. Review the data
2. Determine the reason for non-compliance
3. If appropriate, develop a corrective action plan with a timeline that will achieve remediation within 15 working days from the date the county was notified by the CMS Branch, where possible

If remediation is not achievable within 15 working days, a note from the CCS County, or *State CMS,* documents the reason for the delay, the manager's approval, and the timeframe for remediation.

Documentation (using case notes in CMSNet and entries in the PFC Access database) of the steps noted above also include any suggestions for preventing similar failures in the future, i.e. suggested system or process changes. The CMS Branch follows up with the CCS county to ensure that the corrective action plan was completed within the specified timeframe.

State CMS uses the systemic quality improvement strategy, defined in Appendix H, to monitor compliance and success of the program across all performance measures.

b.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)*
	X *State Medicaid Agency*	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		X *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.

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

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

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

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

Select one Waiver Target Group	Target Group/Subgroup		Minimum Age	Maximum Age: Maximum Age Limit: Through age –	Maximum Age: No Maximum Age Limit
X	**Aged or Disabled, or Both** *(select one)*				
	☐	**Aged or Disabled or Both – General** *(check each that applies)*			
	☐	Aged (age 65 and older)			☐
	☐	Disabled (Physical) (under age 65)			
	☐	Disabled (Other) (under age 65)			
	X	**Specific Recognized Subgroups** *(check each that applies)*			
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	X	Medically Fragile	0	20	☐
	X	Technology Dependent	0	20	☐
○	**Mental Retardation or Developmental Disability, or Both** *(check each that applies)*				
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
○	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness (age 18 and older)			☐
	☐	Mental Illness (under age 18)			

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

Medi-Cal beneficiaries through the age of 20 who have the following life limiting, life threatening CCS eligible medical conditions:

- Neoplasms
  - Stage 3 or 4
  - Any neoplasm not responding to conventional protocol (at least one relapse)
  - Central nervous system tumors
- Cardiac
  - Major cardiac malformations for which surgical repair is not an option or awaiting surgery or transplant
  - Severe anomalies of aorta and/or pulmonary arteries
  - Refractory pulmonary hypertension
- Pulmonary
  - Cystic fibrosis with multiple hospitalizations or emergency department visits in the previous year
  - Chronic or severe respiratory failure
- Immune
  - AIDS with multiple hospitalizations or emergency department visits in the previous year
  - Severe combined immunodeficiency disorder
  - Other severe immunodeficiencies
- GI
  - Chronic intestinal failure dependent on TPN or awaiting transplant
  - Other severe gastrointestinal malformations
  - Liver failure in cases in which transplant is not an option or awaiting transplant
- Renal
  - Renal failure in cases in which dialysis, transplant are not an option, or awaiting transplant
- Neurologic
  - CCS eligible severe brain malformations with multiple hospitalizations or emergency department visits in the previous year
  - CNS injury with severe comorbidities
  - Severe cerebral palsy/ hypoxic ischemic encephalopathy with recurrent infections or difficult-to-control symptoms
  - Batten disease
  - Severe neurologic sequelae of infectious disease or trauma
- Metabolic
  - Severe and progressive metabolic disorders including but not limited to: leukodystrophy, Tay-Sachs disease, and others with severe comorbidities
  - Mucopolysaccharidosis that meets Level of Care criteria (B-6:d)
- Neuromuscular
  - Muscular dystrophy requiring ventilatory assistance (at least nocturnal BiPAP) or with multiple hospitalizations in previous year
  - Spinal muscular atrophy, type I or II

- Other myopathy or neuropathy with severity that meets Level of Care criteria (B-6:d)

- Other conditions that meet Level of Care criteria (B-6:d), including but not limited to:
  - Severe epidermolysis bullosa
  - Severe osteogenesis imperfecta
  - Congenital infection with severe sequelae (e.g. CMV, HSV, toxoplasmosis)
  - Post-organ transplant with complications

Within these categories of chronic complex conditions, CCS clients are at risk of frequent hospitalization but for the availability of the waiver services.

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
X	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):
	The participant and/or parent/legal guardian is advised that waiver services will terminate upon the child reaching 21 years of age. Transition planning begins at age 19 and continues until the end of the participant's 20th year. Persons reaching age 21 who remain categorically eligible for Medi-Cal are eligible for state plan services, which include hospice care. If a participant is eligible for another HCBS waiver and space is available, the participant may be enrolled if he/she chooses.

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

X	**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
	○ Other *(specify)*:
○	**Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c*.
○	**Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c*.
	The cost limit specified by the State is *(select one)*:
	○ The following dollar amount: $ _____
	The dollar amount *(select one)*:
	○ Is adjusted each year that the waiver is in effect by applying the following formula:
	○ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

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	○	The following percentage that is less than 100% of the institutional average:	%
	○	Other – *Specify:*	

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

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

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

Appendix B-3: Number of Individuals Served

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

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	1800
Year 2	1800
Year 3	1800
Year 4 (renewal only)	1800
Year 5 (renewal only)	1800

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)*:

X	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	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

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

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

Table B-3-c		
Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

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

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

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

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

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

Prospective waiver participants are referred to a CCS County program participating in the waiver for determination of waiver eligibility. The CCS Nurse Liaison (CCSNL) determines if the applicant meets waiver criteria, based upon the information provided, as described in detail in B-6:2(d). If waiver slots are available, the CCSNL assesses the applicant for enrollment and provides the participant and/or parent/legal guardian with information on the waiver. If the waiver benefits are desired but no waiver slots or providers are available, prospective waiver participants meeting the waiver criteria are placed on a statewide waiting list based on the applicant's eligibility date. The CCSNL sends a letter to the prospective participant and/or parent/legal guardian indicating the effective date of placement on the waiting list. To ensure waiver applicants are provided fair and equitable statewide access to waiver slots, *State CMS* maintains the waiting list based upon the applicant's eligibility date. The waiting list is assessed, analyzed and trends identified on a quarterly basis. Federal CMS will be informed annually of any substantial increase in the number of eligible individuals who are "waitlisted" because no slots are available and for whom the State cannot provide comparable services via other Medi-Cal or state-funded programs.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

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

○	Phased-in
○	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

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

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

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

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

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

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

a. a-1. State Classification. The State is a *(select one)*:

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

a-2. Miller Trust State.
Indicate whether the State is a Miller Trust State.

○	Yes
X	No

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

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
X	Low income families with children as provided in §1931 of the Act		
X	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
X	Optional State supplement recipients		
X	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	X	100% of the Federal poverty level (FPL)	
	○	%	of FPL, which is lower than 100% of FPL
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
☐	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 the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		
	All other mandatory and optional eligibility groups under the Medi-Cal state plan are included.		
Special home and community-based waiver group under 42 CFR §435.217)			

Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed	
X	**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)
○	% of FBR, which is lower than 300% (42 CFR §435.236)
○	$ which is lower than 300%
☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
☐	Medically needy without spend down in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)
☐	Aged and disabled individuals who have income at: *(select one)*
○	100% of FPL
○	% of FPL, which is lower than 100%
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:

Appendix B-5: Post-Eligibility Treatment of Income

Not applicable… 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.

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

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

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

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is *(insert number):*	
	1	
ii.	**Frequency of services**. The State requires *(select one)*:	
	X	The provision of waiver services at least monthly
	○	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

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

	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*:
X	Other (*specify*):
	Sub-state Entity: County CCS office. The CCS program utilizes both DHCS staff and sub-state entity (county) staff to operate the CCS program. The CCS program is operated by DHCS, the single state Medicaid agency, which administers the CCS program through Children's Medical Services. (See also D-1:d)

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:

The individual(s) responsible for determining the level of care (LOC) evaluation for waiver applicants is either a registered nurse case manager or a physician medical consultant employed by the participating county CCS Program. Most nurse case managers have a Bachelor of Science degree in nursing with a Public Health Nurse certificate. For purposes of this waiver, the CCS nurse case manager responsible for LOC decisions is known as the CCS Nurse Liaison (CCSNL).

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 LOC is determined by applying the eligibility criteria listed in Appendix B-1:b. In order to justify medical necessity for waiver services, the CCSNL utilizes medical documentation provided by the referring physician (along with the request for waiver services or enrollment), as well as information already available to the CCS program. This waiver serves Medi-Cal beneficiaries under the age of 21 years who meet waiver eligibility criteria and who would, in the absence of this waiver and as a matter of medical necessity (pursuant to W&I Code §14059.5), be expected to require acute hospital services for at least 30 non-consecutive days during the year.

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

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

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

The CCSNL and/or CCS medical consultant reviews supporting medical documentation. Current medical information is used during the initial and periodic LOC evaluations for pediatric palliative care waiver eligibility. Such documentation

may include information from the participant's medical specialists, treating physician or primary care physician. This information is submitted with the request for waiver services evaluation/reevaluation. The result of the decision is entered into the CMSNet case management system, and the dates of evaluations tracked in the PFC database.

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
X	Every twelve months
○	Other schedule (*specify*):

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

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

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)*:

LOC waiver reevaluations are performed annually based on the participant's date of enrollment and whenever there is a significant change in the participant's needs and/or condition. *State CMS* staff monitors county LOC decisions for compliance by reviewing data extracted through standardized queries in CMSNet and the PFC database.

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:

Copies of the participant's medical records submitted by CCS approved providers are maintained and available on-site at the local CCS county office participating in the project. Electronically retrievable documentation of case management decisions are maintained in CMSNet and the PFC database.

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**

a.i.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.

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

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

Performance Measure: **LOC ~initial**	**Number and percent of new enrollees that received an initial LOC determination prior to receiving Waiver services** Numerator: number of new enrollees with an initial LOC Denominator: a representative sample of new enrollees		
Data Source [e.g. – examples cited in IPG]	***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)*
Record review – off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	95%
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

State:	
Effective Date	

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)*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

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

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

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

Performance Measure: **LOC ~annual**	**Number & percent of participants who received an annual redetermination within 12 months of their initial or last LOC** Numerator: number of participants with annual LOC redetermination Denominator: a representative sample of participants		
Data Source [e.g. – examples cited in IPG]	***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)*
Record review – off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence*

State:	
Effective Date	

			Interval =
	☐ Other: Specify:	**X** *Annually*	95%
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
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)*	
	X *State Medicaid Agency*	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	**X** *Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

a.i.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.

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

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

Performance Measure: **LOC ~process (1)**	**Number & percent of LOC determinations that were made on the state's approved form** Numerator: number of LOCs on approved form Denominator: a representative sample of LOCs		
Data Source [e.g. – examples cited in IPG]	***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:	
Effective Date	

Record review – off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	95%
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
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)*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure: **LOC ~process (2)**	**Number & percent of participants whose LOC determination was made with LOC criteria accurately applied** Numerator: number of LOCs using criteria Denominator: a representative sample of LOCs		
Data Source [e.g. – examples cited in IPG]	***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)*
Record review – off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*

State:	
Effective Date	

	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	95%
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
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)*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

a.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

b.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.*

State CMS provides ongoing monitoring of Level of Care activities, including if:

- An LOC evaluation for a potential applicant was not performed
- An annual reevaluation of a participant was not conducted
- The appropriate instruments and criteria, as described in the waiver, were not utilized to conduct the LOC determination

Upon discovery *State CMS*, within 15 working days, contacts the participating county(s) to:

1. Review the data
2. Determine the reason for non-compliance
3. If appropriate, develop a corrective action plan with a timeline that will achieve remediation within 15 working days from the date the county was notified by the CMS Branch, where possible

If remediation is not achievable within 15 working days, a note from the CCS County, or *State CMS,* documents the reason for the delay, the manager's approval, and the timeframe for remediation.

Documentation (using case notes in CMSNet, and entries in the PFC Access database) of the steps noted above also includes any suggestions for preventing similar failures in the future, i.e. suggested system or process changes. *State CMS* follows up with the CCS county to ensure that the corrective action plan was completed within the specified timeframe.

Should a participating CCS county discover non-compliance, as it relates to LOC sub-assurances, it is the responsibility of the CCSNL to begin the remediation process within 15 working days, including all steps noted above, as appropriate to the sub-assurance in question.

State CMS uses the systemic quality improvement strategy, defined in Appendix H, to monitor compliance and success of the program across all performance measures.

b.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)*
	X *State Medicaid Agency*	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	X *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		X *Continuously and Ongoing*
		☐ *Other: Specify:*

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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.

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

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-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).

The CCSNL and/or CCS medical consultant is responsible for describing alternatives of care available to the participant and/or parent/legal guardian. Printed materials describing these care alternatives are provided. These individuals are provided with the information and advice necessary to enable informed choice between institutional or home and community based waiver services for which they are eligible. In addition, the participant and/or parent/legal guardian is informed that the waiver services are available only until the participant reaches the age of 21, and other care options that will be available at that time. Participant and/or parent/legal guardian choice shall be documented by a signed form explaining the choice of options available, and confirming the selection or rejection of waiver services.

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.

Both written and electronically retrievable facsimiles of the form are maintained by county CCS programs participating in the project. In addition, an entry is made in CMSNet and the PFC database documenting that the Freedom of Choice document was signed by the participant and/or parent/legal guardian. This data is electronically available to county CCS programs, as well as *State CMS*.

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

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

DHCS employs several methods to ensure meaningful access to waiver services by Limited English Proficient (LEP) individuals, in accordance with §50514 of the Health and Safety Code and §10746 of the W & I Code.

Participating counties and waiver providers are required to provide both interpreter and translation services to applicants, participants and their families in the Medi-Cal threshold languages most commonly encountered in that county. Threshold languages are: Armenian, Cambodian, Chinese, Farsi, Hmong, Korean, Russian, Spanish, and Vietnamese. A "threshold" is defined as 3,000 beneficiaries or 5% of the Medi-Cal population within a county (whichever is lower) whose primary language is other than English.

Language services include, as a first preference, the availability of bilingual staff who can communicate directly with applicants, participants and their families in their preferred language. When such staff members are not available, face-to-face interpretation provided by trained staff, or contract or volunteer interpreters, is the next preference. For languages where there is no staff on site, translation will be covered by aligning with a specific language or ethnic center such as Asian Health Services or by utilizing telephone interpreter services such as the AT&T Language Line.

DHCS furnishes participating counties and waiver providers with translated written materials in English and Spanish, as well as threshold (prevalent) languages most commonly encountered in the county. 42 CFR Section 438.10 describes "prevalent" as those non-English languages spoken by a significant number or percentage of potential enrollees and enrollees.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

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

Statutory Services *(check each that applies)*

Service Type	Included	Alternate Service Title (if any)
Statutory Service	X	Care Coordination
Statutory Service	☐	Home Respite Care
Statutory Service	☐	Personal Care
Other Service	X	Expressive Therapies
Other Service	☐	Family Counseling
Other Service	☐	Family Training
Other Service	☐	Out-of-Home Respite Care
	☐	

Other Services *(select one)*

○	Not applicable
X	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Family Counseling
b.	Expressive Therapies
c.	Family Training
d.	Out of Home Respite (Facility)
e.	Pain and Symptom Management
f.	
g.	

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h.	
i.	
Extended State Plan Services *(select one)*	
X	Not applicable
○	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	
b.	
c.	
Supports for Participant Direction *(check each that applies)*	
☐	The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.
☐	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.
X	Not applicable

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants *(check each that applies)*:

X	As a waiver service defined in Appendix C-3 (*do not complete 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. NOTE: Pursuant to CMS-2237-IFC* this selection is no longer available for 1915(c) waivers.
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.*

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

Appendix C-3: Waiver Services Specifications

Appendix C-3 has been incorporated into section C-1 in the web portal, so it now comes before C-2 in this document.

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

Service Specification	
Service Title:	**Home Respite Care**
Service Definition (Scope)**:**	
Respite care is provided on an intermittent or short term basis. Respite care includes: care and supervision to protect the participant's safety; relief for family members from the constantly demanding responsibility of caring for a child with a serious complex medical condition; and care which meets the participant's medical needs and Activities of Daily Living (ADL). Home respite care is provided in the participant's residence and may require different provider skill levels to meet the individual needs of the participant. The respite benefit may be intermittent or regularly scheduled. Care providers may include individual registered nurses or HHA/HA employed registered nurses, licensed vocational nurses or certified home health aides. Relatives who meet provider requirements (see C-2:e) may also provide this service. The need for and frequency of respite care is identified by the participant and/or parent/legal guardian and Care Coordinator. This is documented in the Family-Centered Action Plan (F-CAP) and transmitted to the CCSNL for authorization. Respite care is provided by one service provider or by a service provider who is supervised by another provider. For example, respite care could be provided by an LVN who is supervised by an RN, or in other cases the care could be provided by an RN acting alone. This may depend on the complexity of the care or other factors.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Up to 30 days (combined home and out of home respite care) per year as described in F-CAP	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	**X**	Individual. List types:	**X**	Agency. List the types of agencies:
	Relatives who meet the qualifications in C-3 for RN or LVN		Home Health Agency	
	Registered Nurse		Hospice Agency	
	Licensed Vocational Nurse			
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	**X**	Relative/Legal Guardian
Provider Qualifications (*provide the following information for each type of provider*):				

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Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency	22 CCR §§74600 et seq.		
Hospice Agency	22CCR §§51180.1-51180.7	22 CCR §51250	
Registered Nurse	HHA: 22 CCR §§ 74600 et seq. §§74651 RN: 22 CCR §51067, 16 CCR §§1409-1419.4; B & P Code §§2725 et seq.		Pediatric experience and education standard
Licensed Vocational Nurse	22 CCR §74631, LVN B & P Code §§2859-2874, 22 CCR §51069		Pediatric experience and education standard
Certified Home Health Aide	22 CCR §§74600 et seq., §74624		Pediatric experience and education standard
Individual: RN LVN	RN: 22 CCR §§51067; 16 CCR §§1409-1419.4 LVN: B & P Code §§2859-2874; 22 CCR §51069		Training and expertise provided by Home Health/Hospice Agency and/or other trained family members

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	CDPH Licensing & Certification	Every 12 months
Hospice Agency	CDPH Licensing & Certification	Every 12 months
Registered Nurse	California Board of Registered Nursing	Biennially
Licensed Vocational Nurse	California Board of Vocational Nursing and Psychiatric Technicians	Biennially
Certified Home Health Aide	CDPH Licensing & Certification	Every 12 months

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Out of Home Respite Care**
Service Definition (Scope)**:**	
Out of home respite care is provided outside the home in a Congregate Living Health Facility and is furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care. The services provided in an approved out-of-home location include appropriate care and supervision to ensure the participant's safety and care which meets the participant's medical needs and ADLs.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Up to 30 days (combined home and out of home respite care) per year as described in F-CAP	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	**X**	Agency. List the types of agencies:
				Congregate Living Health Facility

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Congregate Living Health Facility	H & S Code §§ 1250 et seq.; 22 CCR §§51246 et seq.		Staff available with pediatric care experience

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Congregate Living Health Facility	State Medicaid Agency	Upon Medi-Cal provider enrollment

State:	
Effective Date	

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Care Coordination**
Service Definition (Scope)**:**	

Case Management (entitled Care Coordination) is a waiver service and includes development and implementation of the Family-Centered Action Plan (F-CAP), home visits for regular monitoring of the health and safety of the waiver participant and central coordination of medical and psychological services.

Administrative activities (specifically utilization management; i.e. review and authorization of service requests, level of care determinations, and waiver enrollment) are provided by the CCSNL at the county CCS office. These activities are not waiver services. The CCSNL is funded through the county CCS administrative budget.

Care Coordination is a service authorized to a provider of the participant's and/or parent/legal guardian's choice. The Care Coordinator provides coordination of the multifaceted array of services. This approach enables the participant to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital. Additionally, a key function of the Care Coordinator is to assume a large part of the burden of responsibility, otherwise placed on the parents, for condensing, organizing, and making accessible to providers critical information that is related to care and necessary for effective medical management. The activities of the Care Coordinator allows for a seamless system of care.

The Care Coordinator is responsible for:

- Optimizing care through:
  - Facilitation of access to care
  - Family centeredness
  - Cultural competence
  - Qualified providers
- Maximizing and sustaining participant and Family Unit quality of life
- Meeting the participant's and Family Unit's goals and objectives through:
  - Strong working relationship with the CCS Nurse Liaison (CCSNL)
  - Effective communication, planning, and implementation
  - Understanding of CCS, state, community, and provider resources and limitations
  - Shared decision making
  - A holistic approach to service integration

These responsibilities are achieved through the following:

- Development and implementation of the F-CAP
- Home visits for regular monitoring of health, safety and welfare including home safety assessment
- Regular monitoring of F-CAP performance against expectations

- Regular communication and information sharing with the CCSNL, participant, Family Unit, treating physician and other providers
- Central coordination of medical/psychosocial services
- Ongoing education of participants and Family Unit regarding medical treatment

- Accompanying participant and Family Unit to appointments as necessary such as: physician, school or hospital

In conjunction with the participant/Family Unit, the Care Coordinator develops and implements the F-CAP that responds to social, emotional, spiritual, physical and economic issues that affect the participant/Family Unit's health and maximum potential.

The Care Coordinator works directly with the participant/Family Unit/Circle of Support to develop an F-CAP that identifies:
- Current medical treatment plans with each participating provider
- Treatment or disparities in medical care among multiple providers and milieus
- Qualified local service providers that meet the participant and Family Unit care needs
- Issues that interfere with family functioning and dynamics

The Care Coordinator meets at least monthly with the Family Unit to evaluate progress toward meeting the goals established in the F-CAP planning process. The Care Coordinator and CCSNL maintain a collaborative partnership through open communication to ensure a seamless process of care. This includes sharing the results of the monthly evaluations, observations on health and safety and effectiveness of the F-CAP. The Care Coordinator submits a Service Authorization Request (SAR) for Care Coordination and all other waiver services to CCS annually and as indicated by a significant change in the participant's needs.

If the participant chooses Care Coordination, services are provided at a minimum of four hours per participant per month depending on the individual participant/Family Unit needs.

Care Coordination while participant is admitted in a Health Care Facility:
Agencies may be paid while the participant is admitted in a health facility (as defined in Health and Safety Code section 1250) for CC services provided outside the facility. Supplemental hours (in addition to the eight hours of Care Coordination covered under the regular monthly rate) may be paid incrementally based on the number of admission days during that month. This benefit cannot exceed 60 hours over a period of 90 days.
This payment is necessary to retain the waiver provider for the continuation of services and facilitate the waiver participant's transition back to his/her home environment. In order to receive Care Coordination benefit while admitted in a health care facility, the waiver participant must be enrolled and currently receiving benefits within the prior month of the admission into the health care facility.
Each time the participant is admitted in a health care facility, the Care Coordinator must submit written documentation to the CCSNL describing the specific activities performed, the amount of time each activity required, and the total hours they worked (e.g./ 7:00 a.m. to 11:00 a.m. and 2:00 p.m. to 4:00 p.m.).

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

1. Coordination to resume waiver services after discharge
2. Coordination of services with discharge planner
3. Participation in discharge meetings
4. Environmental/health and safety check of home prior to child's discharge
5. Assistance to Family Unit for physician, school or hospital appointments as necessary. This may include accompanying the family
6. Ongoing communication and information sharing with the CCSNL, participant, Family Unit, treating physician and other providers

Care Coordination providers will not be paid for care that duplicates the care required to be provided by the health care facility to the waiver participants while admitted.

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

Initial Care Coordination Assessment – a one-time payment for up to 22 hours of initial assessment services – billed a set one-time fee.

Monthly Care Coordination – Between 4 and 8 hours of care coordination per month – billed as a set monthly fee.

Supplemental Care Coordination – Up to 60 hours each 90 days of additional care coordination – provided as needed – billed at a per hour rate.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Home Health Agency
				Hospice Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency	22 CCR §§74659 et seq.		
Hospice Agency	22 CCR §§51180.1-51180.7	22 CCR §51250	
Registered Nurse	HHA: 22 CCR §§74651 et seq. RN: B & P Code §§2725 et. seq.; 22 CCR §51067		-A minimum of three years clinical pediatric experience -A minimum of one year clinical End of Life Care experience -End of Life Nursing Education Consortium (ELNEC) or equivalent training within the last five years

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Licensed Marriage Family Therapist (proposed provider type addition)	**B&P Code § 4980-4989.70; 4990-4990.42**		**A minimum of three years clinical pediatric experience, a minimum of one year clinical End of Life Care experience, End of Life Nursing Education Consortium (ELNEC) or equivalent training within the last five years.**
Medical Social Worker with a Masters in Social Work			22 CCR §§74713, 74653 -A minimum of three years clinical pediatric experience -A minimum of one year clinical End of Life Care experience -End of Life Nursing Education Consortium (ELNEC) or equivalent training within the last five years
Licensed Clinical Social Worker	B & P Code §§4991-4998.7 HHA: 22 CCR §79539		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	CDPH Licensing & Certification	Every 12 months
Hospice Agency	CDPH Licensing & Certification	Every 12 months
Registered Nurse	California Board of Registered Nursing	Biennially
Medical Social Worker with a Masters in Social Work	HHA/HA waiver provider	Upon hire and at agency survey intervals
Licensed Clinical Social Worker	California Board of Behavioral Sciences	Every 12 months

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification

Service Title:	**Family Counseling**

Service Definition (Scope)**:**

Family counseling is provided by a Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT), or Licensed Psychologist. These providers should have experience working with children with life limiting illness, and their families, according to palliative care standards described in the Children's Hospice International Program for All-inclusive Care for Children and Their Families (CHI-PACC) model.

An Associate Clinical Social Worker (ACSW) may provide Family Counseling as long he/she meets the criteria referenced in California law. The ACSW must:

- Be registered and approved as an ACSW by the Board of Behavioral Sciences. [B & P Code §§4996. 18, 4996.23].
- Be supervised by an LCSW, or a licensed mental health professional acceptable to the Board of Behavioral Sciences, in accordance with California law and regulations. [B & P Code §4996.23; Cal. Code of Regs., title 16, §§1870, 1874.]
- Provide the service in a setting that lawfully and regularly provides clinical social work, mental health counseling, or psychotherapy. [B & P Code §§4996. 18, 4996.23]
- Inform each client or patient prior to performing any professional services that he or she is unlicensed and is under the supervision of a licensed professional. [B & P Code §§4996. 18, 4996.23]

Family counseling includes grief counseling services prior to the death of the participant.

These waiver counseling services for the Family Unit, as described in the waiver participant's most recent F-CAP, is available for up to one year from the date of death of the participant. Services may take place in the home of the participant/Family Unit or in individual provider settings. The request for these services is transmitted to the CCSNL for authorization.

Claims for family counseling for the Family Unit are billed by the agency using the participant's Client Index Number (a unique identifier assigned to Medi-Cal beneficiaries).

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

Family counseling may be provided to members of the Family Unit for a total of 22 hours. The family unit is informed about the availability and utilization limitations of family counseling when the waiver participant enrolls in the waiver. The parent or legal guardian may opt to have access to family counseling at any time while the child is on the waiver. Requests for family counseling must be made and services initiated prior to the waiver participant's death. A one-time payment for family counseling is made to the agency (home health agency or hospice agency) that is coordinating waiver services for the participant. This payment is made before the death of the waiver participant. In return for this one-time payment, the home health agency or hospice agency provides all family counseling that is identified within the F-CAP within the limits noted above. The payment are the same dollar amount for all and equal the average expected utilization hours of family members (22 hours) multiplied by the average provider hourly rate.

Provider Specifications				
Provider Category(s) *(check one or both)*:		Individual. List types:	X	Agency. List the types of agencies:
				Home Health Agency
				Hospice Agency
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

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

State:	
Effective Date	

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency	22 CCR §§75659 et seq.		
Hospice Agency	22 CCR §§51180.1-51180.7	22 CCR §51250	
Licensed Clinical Social Worker	B & P Code §§4991-4998.7 HHA: 22 CCR §§74600 et seq.		
Licensed Psychologist	B & P Code §§2909 et seq. 16 CCR §§1380 et seq. HHA: 22 CCR §§74600 et seq.		
Marriage and Family Therapist	HHA: 22 CCR §§74600 et seq. MFT: B & P Code §§4980-4989; 16 CCR §§1829-1848		
Associate Clinical Social Worker	B & P Code §§4996.18, 4996.23 CCR title 16, §§1870, 1874		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	CDPH Licensing & Certification	Every 12 months
Hospice Agency	CDPH Licensing & Certification	Every 12 months
Licensed Clinical Social Worker	California Board of Behavioral Sciences	Every 12 months
Licensed Psychologist	California Board of Psychology	Biennially
Marriage and Family Therapist	California Board of Behavioral Sciences	Every 12 months
Associate Clinical Social Worker	California Board of Behavioral Sciences	Every 12 months

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

State:	
Effective Date	

Service Specification	
Service Title:	**Expressive Therapies**

Service Definition (Scope)**:**

Expressive therapies are focused on the participant and contain a wide variety of specialized therapy modalities by providers trained in child development. These therapies help support children to creatively and kinesthetically express their understanding and reaction to their illness. Expressive therapy functions as the interface between the mind and body utilizing creative activity to improve the capacity of the body and mind to heal. These therapists are certified and include a generalist therapy category, commonly known as a Child Life Specialist. Child Life Specialists use play and psychological preparation as primary tools to facilitate coping and adjustment at times and under circumstances that might prove overwhelming in dealing with life threatening illness.

Play and age-appropriate communications may be used to:

- Promote optimal development
- Present information
- Plan and rehearse useful coping strategies for medical events
- Work through feelings about past or impending experiences
- Establish therapeutic relationships with children and parents to support family involvement in each child's care

A participating HHA or HA employs or contracts with these provider types.

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

Up to 60 hours every 90 days

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	**X**	Agency. List the types of agencies:
				Home Health Agency
				Hospice Agency
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency	22 CCR §§4659 et seq.		
Hospice Agency	22 CCR §§51180.1-51180.7	22 CCR §51250	
Child Life Specialist		Certification through Child Life Council	Experience with children who have chronic complex conditions

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Art Therapist		22 CCR §72011 Master's degree in art therapy or in art education or psychology with major course work in art, art therapy, including an approved clinical internship in art therapy. Registered or eligible for registration with the American Art Therapy Association	Experience with children who have chronic complex conditions
Music Therapist		22 CCR §72069 Bachelor's degree in music therapy and who is registered or eligible for registration with the American Music Therapy Association	Experience with children who have chronic complex conditions
Massage Therapist		Certification including at least 500 hours of massage education and training at an approved massage therapy school. B & P Code §4600	Experience with children who have chronic complex conditions

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	CDPH Licensing & Certification	Every 12 months
Hospice Agency	CDPH Licensing & Certification	Every 12 months
Child Life Specialist	HHA/HA waiver provider	Upon hire and at agency

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		survey intervals
Art Therapist	HHA/HA waiver provider	Upon hire and at agency survey intervals
Music Therapist	HHA/HA waiver provider	Upon hire and at agency survey intervals
Massage Therapy	HHA/HA waiver provider	Upon hire and at agency survey intervals

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Family Training**
Service Definition (Scope)**:**	
Family training is defined as training provided by an RN for the Family Unit, Circle of Support or other primary caregivers of waiver participants. Training includes instruction about end of life care, palliative care principles, care needs, medical treatment regimen, use of medical equipment, and how to provide in-home medical care to best meet the needs of the participant. "Family Unit" does not include individuals who are employed to care for the participant.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Up to 100 hours per year	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	**X**	Individual. List types:	**X**	Agency. List the types of agencies:
	Registered Nurse		Home Health Agency	
			Hospice Agency	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency	22 CCR §§74659 et seq.		
Hospice Agency	22 CCR §§51180.1-51180.7	22 CCR §51250	
Registered Nurse	HHA: 22 CCR §§74651 et seq.;		Waiver standards of participation

	B & P Code §§2725 et seq.; 22 CCR §51067; 16 CCR §§1409-1419.4		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	CDPH Licensing & Certification	Every 12 months
Hospice Agency	CDPH Licensing & Certification	Every 12 months
Registered Nurse	California Board of Registered Nursing	Biennially

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification

Service Title:	**Pain and Symptom Management**

Service Definition (Scope)**:**

Pain and symptom management is defined as nursing care in the home by a registered nurse to manage the participant's symptoms and pain. Management includes regular, ongoing symptom and pain assessments to provide relief of suffering. In addition, management may include treatment of distressing symptoms and side effects incorporating pharmacological, non-pharmacological and complementary/supportive therapies. The approach to the relief of suffering is comprehensive, addressing physical, psychological, social and spiritual aspects.

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

100 hours per year.

Provider Specifications

Provider Category(s) *(check one or both)***:**		Individual. List types:	**X**	Agency. List the types of agencies:
				Hospice Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Hospice Agency	22 CCR §§51180.1-51180.7	22 CCR §51250	

State:	
Effective Date	

Registered Nurse	RN: B & P Code §§2725 et. seq.; 22 CCR §51067		-A minimum of three years clinical pediatric experience -A minimum of one year clinical End of Life Care experience -End of Life Nursing Education Consortium (ELNEC) or equivalent training within the last five years

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Hospice Agency	CDPH Licensing & Certification	Every 12 months
Registered Nurse	California Board of Registered Nursing	Biennially

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	**Personal Care**

Service Definition (Scope)**:**

Personal Care is to be used when the services of a hospice home health aide or certified nursing assistant will benefit the child or provide support for the family.

Personal care services can include the following (22 CCR §§51183, 51350):

- Personal Care:
  - Assisting with ambulation
  - Bathing and grooming
  - Dressing
  - Bowel, bladder and menstrual care
  - Repositioning, transfer, skin care, and range of motion exercises.
  - Feeding, hydration assistance
  - Assistance with self-administration of medications
  - Respiration limited to nonmedical services
  - Paramedical services (Welfare and Institutions Code §12300.1)
- Ancillary:
  - Limited Domestic services
  - Laundry services
  - Reasonable food shopping and errands
  - Meal preparation and cleanup
  - Accompaniment to and from appointments
  - Heavy Cleaning
  - Yard hazard abatement

Personal Care is provided by a Home Health Aide or Certified Nursing Assistant (as an agency employee or contract employee). A family member (other than the legally responsible person) may provide the service if they are qualified and contract through the agency.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
6 units per day, no more than 100 hours per year per child

Provider Specifications

Provider Category(s) *(check one or both)*:		Individual. List types:	X	Agency. List the types of agencies:
				Hospice Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

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

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Hospice Agency	22 CCR §§51180.1-51180.7	22 CCR §51250	
Certified Home Health Aide	22 CCR §§74600 et seq., §74624		Pediatric experience and education standard
Certified Nursing Assistant		H&S Code §§1337-1338.5 42 CFR Part 483.75 and 483 Subpart D	Pediatric experience and education standard

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Hospice Agency	CDPH Licensing & Certification	Every 12 months
Home Health Aide	CDPH Licensing & Certification	Every 12 months
Certified Nursing Assistant	CDPH Licensing & Certification	Every 12 months

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Appendix C-2: General Service Specifications

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

X	**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):
	In accordance with H&S Code §1728, HHA and HA owners and administrators are required to submit fingerprints to the California Department of Justice prior to issuance of their license. If the agency receives a conditional license prior to completion of these checks, no patient contact is permissible until completion of the check. Certified Nurse Assistants (CNAs) and Certified Home Health Aides (CHHAs) are also required to obtain fingerprint clearance in accordance with H & S Code §1337 and §1736.6 respectively, through the California Department of Justice. Compliance is monitored by the California Department of Public Health (CDPH). Neither category of lay personnel may practice until clearance is obtained. HHAs and HAs will routinely check their professional personnel, nurses, therapists, and counselors when they are hired. Licensed professionals, including registered nurses, licensed vocational nurses, physicians, social workers, Marriage and Family Therapists (MFTs) practicing in the state, are required by their individual boards to submit fingerprints upon licensure. There are no statutes compelling them to have repeat checks thereafter. CLHF facilities are also required to do background checks of employees. CLHFs are required to comply with Title 22 Div. 5 Chapter 3 - skilled nursing facilities, which includes the background check.
○	**No**. Criminal history and/or background investigations are not required.

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

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

State:	
Effective Date	

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

X	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
○	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

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

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

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

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

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

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

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

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

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

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

○	The State does not make payment to relatives/legal guardians for furnishing waiver services.
X	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the

	services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
	Payment to relatives may be made for certified nursing assistant or nursing services only for purposes of providing respite care (see Appendix C-3). Relatives providing these services shall meet the provider qualifications listed in C-3 and be either employed by the authorized HHA/HA providing waiver benefits to the child; or if an independent nurse provider, proof of enrollment as a Medi-Cal provider with an active Medi-Cal provider number. All respite services require documentation in the Family-Centered Action Plan (F-CAP) and must be prior authorized by the CCSNL. Independent nurse providers must provide documentation of agreement and method of coordinating services with authorized HHA/HA. Respite is limited to 30 days per year. Payment to relatives may be made for certified nursing assistants or home health aides only for purposes of providing personal care (see Appendix C-3). Relatives providing these services shall meet the provider qualifications listed in C-3 and be either employed by the authorized HHA/HA providing waiver benefits to the child; or contracted by the agency. The exception to this is that a participants' legally responsible person(s) may not be paid to provide this service. All personal care services require documentation in the Family-Centered Action Plan (F-CAP) and must be prior authorized by the CCSNL. Personal Care is limited to 100 hours per year.
○	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
○	Other policy. *Specify*:

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

Any home and community based Medi-Cal provider delivering services in one of the participating counties can apply to *State CMS* to participate in the waiver. In order to be approved they must meet the PFC standards of participation. Medi-Cal provider enrollment applications are available, for those providers not currently enrolled, on-line or by calling the Medi-Cal Provider Enrollment Division.

Provider recruitment efforts have continued since PFC's inception. *State CMS* has partnered with Children's Hospice and Palliative Care Coalition (CHPPC), a non-profit organization that aims to improve healthcare systems for children with life threatening conditions and their families, in the development and implementation of the waiver. Current efforts on the part of *State CMS* and CHPCC to recruit agencies and interested individual nurse providers to serve as PFC providers have included meetings with, and presentations to, hospice and home health agencies' administrative staff and board of directors to understand and resolve agencies' issues with participation, Grand Rounds at referring children's hospitals, and presentations and Q&A sessions at hospice and home health state conventions. In addition, an active, ongoing, online communications campaign regularly distributes updates and information on PFC to the membership distribution lists of CHPCC, California Hospice and Palliative Care Association (CHAPCA), and the Compassionate Care Coalition of California (CCCC). The e-mail communiqués include a direct link to the CCS website and PFC provider application.

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**

a.i.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.

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

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

Performance Measure: **PROVIDERS ~licensure/certification**	**Number & percent of waiver providers, by provider type, who have current appropriate licensure/certification in accordance with state law and waiver provider qualifications** Numerator: number of providers with current qualifications Denominator: a representative sample of providers		
Data Source 1 ***[e.g. – examples cited in IPG]***	***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)*
Provider performance monitoring	**X** *State Medicaid Agency*	☐ *Weekly*	**X** *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	

State:	
Effective Date	

		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Source 2 ***[e.g. – examples cited in IPG]***	***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)*
Record review – off-site	**X** *State Medicaid Agency*	☐ *Weekly*	**X** *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
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)*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

a.i.b Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

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

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

Performance Measure: **PROVIDERS ~non-licensed/non-certified**	**Number & percent of non-licensed/non-certified providers, by provider type, who meet state/waiver provider qualifications** Numerator: number of providers who meet waiver requirements Denominator: a representative sample of providers		
Data Source [e.g. – examples cited in IPG]	***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)*
Record review – off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	95%
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
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:	
Effective Date	

	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

a.i.c Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

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

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

Performance Measure: **PROVIDERS ~training**	**Number and percent of providers, by provider type, meeting provider training requirements** Numerator: number of providers who meet training requirements Denominator: a representative sample of providers		
Data Source [e.g. – examples cited in IPG]	***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)*
Record review – off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	95%
		☐ *Continuously and*	☐ *Stratified:*

		Ongoing	*Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
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)*	
	X *State Medicaid Agency*	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	**X** *Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

a.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

b.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.*

Upon discovery of a provider not meeting waiver standards for participation (including licensure/certification, qualification requirements for non-certified/non-licensed providers and training), *State CMS*, within 5 working days, notifies the provider agency of the non-compliance. *State CMS* requests resolution of any missing, incomplete or incorrect documentation and gives a deadline for response. *State CMS* also notifies Licensing and Certification (L&C) when issues may pose a direct threat to participant or family health and welfare.

Should a participating CCS county discover non-compliance, as it relates to provider qualification sub-assurances, it is the responsibility of the CCSNL to contact *State CMS* to begin the remediation process within 5 working days. Any non-compliance discovered by L&C is shared with *State CMS* at the time of discovery.

If the missing documentation has not been received and the provider has taken no action to address deficiencies within 15 days after the first notice, a second notice will be sent. The second notice will include a deadline for compliance and identify consequences for non-compliance.

If there is no response (or insufficient response) from the provider, 15 days after the second notice *State CMS* contacts the CCSNL to:

1. Discuss the non-compliance
2. Review the data
3. Determine the reason for non-compliance
4. Determine possible corrective actions

Within 15 days of the above discussion, *State CMS* sends the provider a notice outlining the continued noncompliance and informs the provider that a teleconference with *State CMS* and CCSNL(s) will be arranged to:

- Discuss deficiencies
- Describe possible corrective actions developed during *State CMS*\CCSNL discussion
- Develop a corrective action plan with timeline for remediation

After the deadlines established in the corrective action plan timeline have passed, and remediation has not been achieved, *State* CMS notifies the CCSNL who, if appropriate:

- Discontinues all service authorizations to the provider/agency
- Notifies the Care Coordinator(s) that PFC services through their agency are being discontinued
- Works with each family to choose another qualified provider
- Ensures that services for any non-compliant provider will not be authorized until remediation is completed

Documentation on the provider master list of the steps noted above also includes any suggestions for preventing similar failures in the future.

State CMS uses the systemic quality improvement strategy, defined in Appendix H, to monitor compliance and success of the program across all performance measures.

b.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)*
	X *State Medicaid Agency*	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	X *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		X *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.

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

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

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

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

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

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above*.
☐	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above*.
☐	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above*.
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*
X	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Family-Centered Action Plan (F-CAP)

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 *(check 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
☐	Licensed physician (M.D. or D.O)
☐	Case Manager (qualifications specified in Appendix C-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
X	Social Worker. *Specify qualifications:*
	Medical Social Worker with a Masters in Social Work Licensed Clinical Social Worker (LCSW)
☐	Other (*specify the individuals and their qualifications):*

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

○	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
X	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:
	State CMS is responsible for providing/facilitating technical assistance and training for waiver providers regarding pediatric palliative care and F-CAP development, as well as policy and technical guidelines needed to ensure participant- and family-centeredness. The palliative care modules have been developed by *State CMS*. A standard assessment tool and options for care has been developed, in consultation with provider stakeholders, to emphasize the interests of the participant and Family Unit, as well as maintain consistency within the program. *State CMS* is responsible for monitoring and reporting participant- and family-

centeredness, effectiveness and efficiency of the F-CAP as part of its mandated quality assurance responsibilities. Monitoring and reporting is accomplished by tracking those who contribute to the development of the F-CAP, adherence to guidelines and tools, and family satisfaction with the services provided. The CCSNL contacts participant families monthly to assure that services authorized, services provided and the F-CAP meet the participant's/family unit's goals and objectives.

State CMS monitors the F-CAP development and implementation. All services requested by the Care Coordinator through the F-CAP are reviewed for medical necessity through the prior authorization process. The participant, Family Unit, and Circle of Support are included in the decision making process. Patient satisfaction and quality of life are monitored at intervals during participation. CCSNL calls and State F-CAP reviews provide the data for this assurance.

In addition to the above safeguards, the HHA/HA is responsible for providing *State CMS* with a quality assurance plan for identifying and addressing client based and agency-wide issues. Annually, the agency is responsible for submitting a Quality Assurance report. This report shall document procedures, compliance, challenges faced, and resolutions for each Assurance below.

Qualified Providers

- Monitoring of qualifications: Facility license; licensed/certified staff members
  - Including submission of updates to *State CMS* as appropriate
- Monitoring of qualifications: Non-licensed/non-certified staff members; contractors
  - Including submission of updates to *State CMS* as appropriate
- Monitoring and documentation of participation in Waiver training
  - At least one staff member must attend the State-led training who may then train other staff members (training must include Health & Welfare policies)

Service Plans

- Monitoring of the F-CAP development and review process to ensure that each plan appropriately identifies and addresses participant needs and goals
- Monitoring of the F-CAP development and review process to ensure that each plan follow *State CMS* policies and procedures appropriately
  - Including communication with Special Care Center staff, Primary care providers, community providers, Circle of Support and CCSNLs
  - Including submission of plans for CCSNL review

- Monitoring of the F-CAP review process to ensure that each plan is reviewed on schedule (6 month full and 60 day partial reviews)
- Monitoring of the F-CAP review process to ensure that each plan is also reviewed and revised as needed
- Monitoring of the F-CAP review process to ensure that services delivered match each plan

Health and Welfare (H&W)

- Monitoring of H&W to ensure that incidents are reported and documented in a timely manner
- Monitoring of H&W to ensure that for each incident appropriate corrective action has been taken, documented and reported
- Monitoring of H&W content included in staff member training
- Monitoring of the F-CAP review process to ensure that each plan includes a participant H&W assessment

Financial

- Documentation of claims process and problems encountered

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.

The CCSNL and the Care Coordinator provide information to the participant or parent/legal guardian regarding the range of services and supports available. The enrollment documents include English and Spanish versions of the: waiver freedom of choice form, participant/parent agreement form, services description sheet (both parent and participant versions), F-CAP development process sheet, child abuse/health and welfare reporting information, and the PFC family flyer.

The participant and Family Unit are encouraged to invite individuals of their choice to actively participate in the care planning process (Circle of Support, refer also D-1-d)**.** The participant's selection of his/her advisors in this process is determined by the concurrence of the participant and the parent/legal guardian, in compliance with state and federal laws regarding capacity and authority to consent to medical treatment (informed consent) and privacy (Health Insurance Portability and Accountability Act and civil rights).

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):

The Service Plan is referred to, in this document, as the Family-Centered Action Plan (F-CAP). The F-CAP development requires the coordination of multiple processes which begins with the assessment of the prospective participant by the CCSNL for CCS, Medi-Cal, and waiver eligibility. The participant and parent/legal guardian's education regarding waiver benefits and choices for F-CAP development begins at this point. If this process results in acceptance of waiver benefits, the participant and/or parent/legal guardian acknowledges by signing the enrollment agreement.

The CCSNL provides the participant and/or parent/legal guardian with a directory containing the available qualified providers serving the county in which they live. Upon selection and acceptance of a waiver provider, the CCSNL contacts the provider and refers the participant. The Care Coordinator schedules a face-to-face meeting to assess participant needs. This assessment includes the treating physician's medical recommendations and the psychosocial needs of the participant and Family Unit. The Care Coordinator is responsible for information gathering, development and implementation of the F-CAP.

Role Descriptions

CCS Program

The county CCS programs provide utilization management and authorization of services for children under 21 years of age with a CCS eligible condition who meet CCS program requirements, which includes all participants in this Medi-Cal waiver. The CCS program utilizes both DHCS staff and sub-state entity (county) staff to operate the CCS program. The CCS program is operated by DHCS, the single state Medicaid agency, which administers the CCS program through Children's Medical Services. The CCSNL provides utilization management and service authorization for waiver participants. These activities include ensuring that participants get to the appropriate provider of services at the appropriate time and

place. CCS utilization case management also encompasses authorization of medically necessary services to treat the participant's CCS eligible medical condition. Additionally, the CCSNL provides concurrent review of medical documentation to adjudicate authorizations for services anticipated over the next 3-6 months.

Special Care Centers (SCC) provide health care to CCS and Genetically Handicapped Persons Program (GHPP) clients with specific medical conditions. SCCs are organized around a specific condition or system. SCCs are comprised of multi-disciplinary, multi-specialty providers who evaluate the client's medical condition and develop a medical treatment plan. For this waiver, the Special Care Centers are an important source of referrals. For waiver participants, SCCs will continue to provide specialized medical care through their interdisciplinary team. They will also collaborate with the Care Coordinator to share information based on the needs of the participant and to ensure there is no duplication of services.

CCS Nurse Liaison

The CCSNL provides utilization management and service authorization to waiver participants. The CCSNL is responsible for enrolling the child into the waiver, evaluating needs for services requested, authorizing all state plan and waiver services through the Service Authorization Request (SAR) process, and tracking all services authorized. In addition, the CCSNL notifies the participant or parent/legal guardian, if applicable, of the provision that waiver services are available only until the participant reaches the age of 21, at which time the participant will be assisted with the transition to other available service programs. The CCSNL is responsible for entering all participant data into the PFC access database.

On an ongoing basis, the CCSNL reviews the content of the F-CAP to verify that the services requested are appropriate to meet the care needs and goals identified in the F-CAP. The reviews ensure all pieces of the F-CAP are appropriate including health and welfare assessments. In addition, the CCSNL contacts waiver participants monthly and waiver providers regularly to ensure that all services are delivered in accordance with the F-CAP. Utilization management includes assessment of the frequency, amount and duration of all services (waiver and state plan) through paid claims review, authorizations issued in CMSNet, ongoing dialogue with the Care Coordinator, as well as evaluating the appropriateness and eligibility of providers selected. The CCSNL reviews the F-CAP regularly and with each additional request for waiver services. The CCSNL is the Care Coordinator's CCS contact and provides guidance as needed to ensure compliance with waiver requirements. The CCSNL and other county staff participate in monthly teleconferences with *State CMS*. Ongoing communication between the CCSNLs and *State CMS* includes technical assistance, policy questions, provider issues, program improvements, etc.

Care Coordinator (RN, MSW, LCSW)

The core function of the Care Coordinator is to ensure a seamless system of care. S/he facilitates, develops and implements the F-CAP including communication of goals and plan of care to all healthcare providers involved in the care of the participant, as well as the Family Unit. A key component of the Care Coordinator role is to maintain open communication between CCS, the medical care providers and the participant/Family Unit to achieve integration of family needs and medical goals. The Care Coordinator assists the participant and Family Unit in understanding recommended changes to the medical regimen as they occur and continuously reviews and updates the goals of care as needed. Assistance may include accompanying participant/Family Unit to appointments to schools, clinics, or other medical/therapy appointments. The Care Coordinator facilitates communication between the care providers and the family when needed.

The Care Coordinator is responsible for developing and implementing the F-CAP, as well as requesting authorization from the CCS program for all services documented in the F-CAP. The Care Coordinator maintains an open dialogue with the CCSNL communicating all issues related to the care of the waiver participant. Where services are available through other sources, such as state plan benefits, private insurance or available community resources, the Care Coordinator collaborates with the CCSNL to assist participants in accessing those services.

Options for services and providers are explained to the participant and Family Unit during the F-CAP development process. The Care Coordinator makes initial and at least monthly home visits for face to face interviews regarding care needs and goals. The Care Coordinator reports directly to the CCSNL all issues concerning the waiver participant. The home visits include evaluation of the home environment for health and safety as well as evaluation of the participant for signs of abuse, neglect, and exploitation.

F-CAP Development Process

The Care Coordinator includes the Family Unit in identifying the participant's care needs and waiver services. In an ongoing effort to achieve integration of family and medical goals, the participant or parent/legal guardian is encouraged to select the waiver service(s) best suited to meet the participant's medical/social needs. Selection of waiver services is also based on medical needs identified by the Special Care Centers (SCC) and medical providers. This is achieved, in part, based on an informative dialogue describing the available waiver, state plan and community services during the development of the F-CAP. The participant and Family Unit may select and invite individuals of their choice (Circle of Support) to actively participate throughout the F-CAP development process. With input from the participant and Family Unit, the Care Coordinator obtains information about the participant's needs, preferences, and goals. Risk factors are identified, analyzed,

and addressed as the F-CAP is developed. The completed F-CAP is forwarded to the CCSNL for review and approval.

The full F-CAP is reviewed, and revised as appropriate, every 6 months. Two partial reviews, in between each 6 month full review, are also required. One review is due 60 days after the 6 month full review, and a second review is due 60 days after that. The Care Coordinator works with the family and other providers to complete these reviews. The PFC Family Centered Team is led by the Care Coordinator and includes the participant/family and CCSNL. This purpose of this meeting is to share any changes to the content of the F-CAP with the family and allow for any further input or changes the family would like to provide. The F-CAP reviews will include sections of the F-CAP that address, at minimum, the child's physical condition and Health and Welfare concerns, as well as the Care Coordinator's goals and integration of the PFC Family Centered Team goals. The F-CAP may also be revised, as necessary between the required scheduled reviews, whenever the participant's needs change.

Care Coordinators use a standardized form for the submission of the initial and subsequent updated F-CAPs. The F-CAP must include the participant's demographic information, treating and primary care physician information, and diagnoses.

The F-CAP includes:

- Patient Information
  - Identifying Information, Diagnosis, Providers
- Health and Symptom Assessments
  - Communication/History
  - Physical Assessment
  - Assessment of Systems
  - Pain Assessment Tool
  - Nutritional Risk Screen
- Family/Social Information
- Health and Safety Assessments
  - Risk Factors
  - Home Environment Assessment
- Perception of Illness/Health Care Goals
  - Patient, Family or Circle of Support, Siblings, Decisions
- Patient, Family, and Circle of Support Desires
- Care Goals by Care Coordinator
- Integration of All Goals
- Current and Requested Services
- Additional Resources – Goals, Family Phone Sheet

The F-CAP process is designed to integrate the participant and Family Unit's goals and medical objectives to ensure that the participant can successfully and safely live in the community.

Following each evaluation visit, the Care Coordinator updates the F-CAP based on the assessment of the status of the participant and evaluation of the effectiveness of the services provided. If it is determined that the existing F-CAP no longer meets the participant's needs, the Care Coordinator, consulting with the treating physician, must submit the updated physician-approved F-CAP to the CCSNL. The Care Coordinator is responsible for assuring that services are provided in accordance with the F-CAP.

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 process of risk assessment begins at the time of initial contact between the CCSNL and the participant and Family Unit. Upon waiver enrollment, ongoing risk assessments is a part of the Care Coordinator's function and addresses medical fragility, psychosocial factors and environmental safety. The findings are documented in the F-CAP. An important aspect of assessment is to determine if the participant's home and community environment is safe and conducive to the successful implementation of an HCBS waiver program.

The environmental evaluation includes assessment of risk factors affecting the participant's health and safety including:

- Family
  - Family violence
  - Drugs / Alcohol
  - Psychiatric history
  - Suicide attempts
  - Access to weapons
  - History of chemical / physical restraints
  - Gang involvement
  - Smoking
  - Restraining orders
- Home Environment/Neighborhood
  - Primary and back-up utilities functioning
  - Pests / Rodents present
  - Telephone available
  - Safety Devices installed and in working order
  - Wheelchair accessibility
  - Home well maintained
  - Pets or other animals present

  - Local emergency responders aware of child
  - Public utilities aware of child
  - Rural / outlying area transportation issues identified
- DME
  - Medical equipment in working order
  - Family knowledgeable in use of medical equipment
  - Family aware of any potential hazards related to certain DME (e.g. oxygen tank)
  - Home can safely accommodate all medical devices, equipment storage and supplies

Mitigation of any environmental risk factors identified during the assessment includes referral to Child/Adult Protective Services, other appropriate agencies or community resources.

The psychosocial impact of the participant's illness places the participant/Family Unit at particular risk for anticipatory grief, isolation from peers, depression, parental distress and/or burnout. Along with care coordination, waiver benefits help to mitigate crises in these risk areas by offering respite and counseling. Individual/caregiver counseling helps to mitigate the feelings of isolation and encourages open dialog between participants and the family caregivers for the purpose of expressing and overcoming feelings of grief and distress. Respite services mitigate parental distress and burnout by providing caregivers with a period of relaxation free from the care giving duties.

Expressive Therapy services allow the participant to safely and effectively express feelings through art, music, massage and play. Child Life Specialist services provide therapeutic and developmentally appropriate activities that are designed to promote self-expression and socialization, to prepare for medical procedures/surgery through medical play and to identify and teach coping mechanisms.

The Care Coordinator develops an emergency backup plan with the input of the participant, Family Unit, treating physician and CCSNL. Considerations include coverage for interruption of scheduled services, loss of usual sources of transportation and unanticipated absence of caregivers.

The F-CAP includes the Care Coordinator's risk evaluation and proposed interventions to mitigate risk, thus enabling the participant to safely receive services at home or in the community.

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.

At the time of waiver enrollment, a directory of available waiver providers is supplied to the participant and parent/legal guardian by the CCSNL. The directory of providers includes information about the providers such as demographics, and cultural and linguistic competence. The CCSNL contacts the selected waiver provider to determine if the provider is willing and able to accept the referral. The Care Coordinator supports the participant and Family Unit by facilitating access to providers for all services identified in the F-CAP.

All qualified providers (Medi-Cal providers who meet standards for participation in the waiver) who have expressed an interest in providing waiver services are included in the directory.

The waiver participant/parent may request a provider not in the directory if that provider is willing. However, if the provider is not already a Medi-Cal provider, they must first go through the Medi-Cal provider enrollment process. DHCS must also determine if they meet the standards for participation as defined in the waiver.

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):

DHCS oversees the service plan process through *State CMS,* which administers the CCS program and the waiver. The CCS program utilizes both DHCS staff and sub-state entity (county) staff to operate the CCS program. In the child's county of residence, the CCS program provides the waiver participant with a CCS Nurse Liaison (CCSNL). The CCSNL, a county CCS program employee, is responsible for authorizing all state plan services, as required in 22 CCR §51013 and all waiver services needed to implement the F-CAP.

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

○	Every three months or more frequently when necessary
X	Every six months or more frequently when necessary
○	Every twelve months or more frequently when necessary
○	Other schedule (*specify*):

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
X	Other (*specify):*
	Hard copies and/or electronic files of the F-CAPs are maintained by the participating county CCS programs and are sent electronically to *State CMS*. HHA and HAs are required to maintain the F-CAP forms in accordance with 45 CFR §164.501 and 22 CCR §41671.

Appendix D-2: Service Plan Implementation and Monitoring

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

State CMS, an administrative entity of the single-state agency (DHCS), monitors and oversees participating county CCS programs and service providers. The CCS program utilizes both DHCS staff and sub-state entity (county) staff to operate the CCS program. The Licensing and Certification (L&C) Program of the California Department of Public Health (CDPH) monitors and ensures that HHA/HA waiver service providers comply with existing DHCS and CDPH policies and procedures, federal and state regulations and waiver requirements, thereby ensuring continued compliance with all licensing and certification regulations. DHCS verifies that providers have been licensed and certified by CDPH before they become approved waiver providers.

L&C provides a complaint line poster and contact number for use by participating agencies, providers and the public.

The families receive a Child Abuse Information Sheet upon enrollment that explains what child abuse is, common signs of child abuse, myths about child abuse, how to report incidents, mandated reporters, and gives family resources.

State CMS staff monitors the waiver utilization management and service authorization activities of the participating county CCS programs to ensure appropriate F-CAP implementation and the health and safety of the participant. This is accomplished through examination of paid claims data and F-CAPs as well as current files/data in CMSNet and the PFC database.

On an ongoing basis, the CCSNL reviews the content of the F-CAP to verify that the services requested are appropriate to meet the care needs and goals identified in the F-CAP. In addition, the CCSNL contacts waiver participants monthly and waiver providers regularly to ensure that all services are delivered in accordance with the F-CAP. Utilization management includes assessment of the frequency, amount and duration of all services (waiver and state plan) through paid claims review, authorizations issued in CMSNet, ongoing dialogue with the Care Coordinator, as well as evaluating the appropriateness and eligibility of providers selected.

State CMS monitors the participating county CCS programs through ongoing:

- Reviews of policies and procedures
- Interviews with the county program CCS Nurse Liaison (CCSNL) and medical consultant

In order to obtain feedback on satisfaction with county CCS programs from families, waiver providers, and referring CCS providers, *State CMS* makes use of Family Satisfaction and Provider Satisfaction Survey tools that are disseminated at least annually to enrollees and providers and upon disenrollment from the waiver.

b. Monitoring Safeguards. *Select one:*

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

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**

a.i.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.

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

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

Performance Measure: **SERVICE PLAN ~participants' needs and goals**	**Number & percent of waiver F-CAPs that are adequate and appropriate to the participant's needs and personal goals** Numerator: number of adequate and appropriate F-CAPs Denominator: a representative sample of F-CAPs		
Data Source [e.g. – examples cited in IPG]	***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)*
Record review – off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*

State:	
Effective Date	

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

a.i.b Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

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

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

Performance Measure:	**Number & percent of F-CAPs and related plan activities that comply with the state's procedures related to plan development**
SERVICE PLAN ~plan development	Numerator: number of F-CAPs that comply Denominator: a representative sample of F-CAPs

State:	
Effective Date	

Data Source [e.g. – examples cited in IPG]	***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)*
Record review – off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	95%
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
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)*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

a.i.c Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

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

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

Performance Measure: **SERVICE PLAN ~updates and revisions (1)**	**Number & percent of participants whose F-CAPs were reviewed and revised at least annually** Numerator: number of participants with F-CAPs reviewed/revised annually Denominator: a representative sample of participants		
Data Source [e.g. – examples cited in IPG]	***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)*
Record review – off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	95%
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
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)*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

State:	
Effective Date	

Performance Measure: **SERVICE PLAN ~updates and revisions (2)**	**Number & percent of waiver F-CAPs that were revised, as needed, to address changing needs** Numerator: number of interim F-CAP revisions that adequately addresses the participant's needs Denominator: number of interim F-CAP revisions		
Data Source [e.g. – examples cited in IPG]	***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)*
Record review – off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	95%
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
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)*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

State:	
Effective Date	

a.i.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.

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

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

Performance Measure: **SERVICE PLAN ~service delivery**	**Number and percent of waiver participants who received services in the type, amount, frequency and duration specified in their F-CAP** Numerator: number of participants whose services received are consistent with their F-CAPs Denominator: a representative sample of participants		
Data Source [e.g. – examples cited in IPG]	***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)*
Record review – off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	95%
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that*	***Frequency of data aggregation and analysis:*** *(check each that*	

State:	
Effective Date	

	applies)	*applies)*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

a.i.e Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.

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

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

Performance Measure: **SERVICE PLAN ~participant choice (1)**	**Number and percent of waiver participants/families who signed a freedom of choice form that specifies choice was offered between institutional care and enrollment in the waiver** Numerator: number of participants with a signed freedom of choice form Denominator: a representative sample of participants		
Data Source [e.g. – examples cited in IPG]	***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)*
Record review – off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	95%

State:	
Effective Date	

		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
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)*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure: **SERVICE PLAN ~participant choice (2)**	**Number and percent of waiver participants/families who signed a freedom of choice form that specifies choice of waiver services and providers were offered** Numerator: number of participants with a signed provider/services freedom of choice form Denominator: a representative sample of participants		
Data Source [e.g. – examples cited in IPG]	***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)*
Record review – off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	95%
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	

State:	
Effective Date	

			☐ *Other: Describe*
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)*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

a.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

b.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.*

State CMS provides ongoing monitoring of Care Plan activities, including if:

- An F-CAP does not address a participant's assessed needs (including health and safety risks and personal goals)
- An F-CAP has not been updated/revised annually or as warranted by changes
- Services were not delivered in accordance with the F-CAP
- State policies and procedures related to plan development were not followed
- A participant was not afforded choice between waiver services, providers or both

Upon discovery, *State CMS*, within 15 working days, contacts the participating county(s) to:

1. Review the data
2. Determine the reason for non-compliance
3. If appropriate, develop a corrective action plan with a timeline that will achieve remediation within 15 working days from the date the county was notified by the CMS Branch, where possible

If remediation is not achievable within 15 working days, a note from the CCS County,

or *State CMS*, documents the reason for the delay, the manager's approval, and the timeframe for remediation.

Documentation (using case notes in CMSNet and entries in the PFC Access database) of the steps noted above also includes any suggestions for preventing similar failures in the future, i.e. suggested system or process changes. *State* CMS follows up with the CCS county to ensure that the corrective action plan was completed within the specified timeframe.

Should a participating CCS county discover non-compliance, as it relates to Care Plan activities sub-assurances, it is the responsibility of the CCSNL to begin the remediation process within 15 working days, including all steps noted above, as appropriate to the sub-assurance in question.

State CMS uses the systemic quality improvement strategy, defined in Appendix H, to monitor compliance and success of the program across all performance measures.

b.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)*
	X *State Medicaid Agency*	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	X *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		X *Continuously and Ongoing*
		☐ *Other: Specify:*

b. 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.

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

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

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) 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.

Waiver applicants, existing participants and/or parents/legal guardians are informed, by a Notice of Action (NOA) letter, of their ability to appeal an adverse decision regarding waiver enrollment or waiver services. An NOA is sent, by the applicable CCS program, to the applicant, existing participant and/or parent/legal guardian when a request for enrollment in the waiver is denied, or when a waiver service has not been approved as requested, is reduced, suspended, terminated or denied. If there is disagreement with a decision the applicant, participant and or parent/legal guardian have the right to request a fair hearing. The authority for the process is found in 22 CCR §§42701 and 42705; and 22 CCR §§51014.1, 51014.2, and 51013. This is a formal administrative process. The CCS Fair Hearing process, including the request, preparation and procedure is found in 22 CCR §§42705, 42707, 42712, and 42713.

As per 22 CCR §51013, CCS is responsible for utilization management and authorization of services for children under 21 years of age with a CCS eligible condition who meet CCS program requirements, including applicants for participation in the waiver. The CCS program utilizes both DHCS staff and sub-state entity (county) staff to operate the CCS program. The *State CMS* exercises oversight of the CCS Program and the waiver. The NOA sent by CCS is on behalf of CCS and the Medi-Cal program, and allows the waiver applicant, participant and/or parent/legal guardian to go directly to a State Fair Hearing (SFH) when a request/application is denied or changed.

Individuals are notified of their right to an SFH by an NOA sent to the applicant, participant and/or parent/legal guardian, within seven calendar days of the decision when the CCS program:

- Denies an initial request for waiver enrollment
- Denies a request for a new waiver service not currently being provided
- Denies continuation of a waiver service currently authorized
- Approves continuation of a waiver service currently authorized but modifies it (to reduce or suspend the frequency or duration of previously authorized waiver services)
- Changes the place or provider of service
- Denies the waiver participant choice of waiver provider(s), except when the provider of choice is unavailable or does not have the capability and capacity to accept and provide the anticipated level of care or intensity based on acuity, age and other factors
- Discontinues the participant's eligibility for the waiver, except when the participant reaches age 21

The NOA includes instructions advising the applicant, participant and/or parent/legal guardian on how and where to request a SFH before an Administrative Law Judge (ALJ) and that the SFH request must be filed within 14 calendar days of the date of the NOA. If the NOA concerns the reduction, suspension, or termination of currently authorized services, and the participant or parent/legal guardian wishes these services to continue during the SFH process, then this must be stated in writing in the request for an SFH.

A request for an SFH is considered late if submitted after the 14 calendar days. All late requests for a CCS SFH will be denied. The written decisions are final unless the applicant, participant and/or parent/legal guardian demonstrate in writing, good cause for the late filing. The decision regarding good cause is made by the Hearing Officer.

Assistance and representation may also be available through organization(s) that provide legal assistance such as nonprofit agencies providing advocacy services under the Developmental Disabilities Assistance and Bill of Rights Act of 1975. The applicable CCS program will continue to work with the applicant, participant and or parent/legal guardian to resolve the contested issues prior to the SFH. A copy of the NOA and request for an SFH is kept in the applicant/participant's CCS file at the CCS program office. The applicant/participant and/or parent/legal guardian have the right to review the applicant/participant's medical records and CCS case file.

The participant's waiver eligibility may be affected in cases where the NOA was issued because the participant no longer met waiver requirements or regular Medi-Cal eligibility requirements.

The DHCS Office of Administrative Hearings and Appeals (OAHA) is designated to conduct fair hearings for the CCS programs. The applicant, participant and/or parent/legal guardian can be self-represented or representation can be delegated to a friend in the participant's Circle of Support, an attorney, or any other person, of their choosing. Representation must be arranged by the applicant, participant and/or parent/legal guardian in advance of the hearing. The Hearing Officer determines the time and place of the SFH. The SFH will be reasonably accessible to the applicant, participant and parent/legal guardian.

OAHA determines whether the request for SFH is specific and complete. If not, OAHA notifies the applicant, participant and/or parent/legal guardian within 14 days. The applicant, participant and/or parent/legal guardian is granted 14 calendar days, after the date of request for information, to submit the additional information. If the information requested is not provided by the applicant, participant and/or parent/legal guardian within 14 days, the Hearing Officer may defer or deny the request for an SFH. The written request for an SFH may be amended by the waiver applicant, participant and/or parent/legal guardian any time during the 14 calendar day period.

The county CCS program furnishes a copy of the discoverable appeal documents to *State CMS,* the Hearing Officer, and the applicant, participant and/or parent/legal

Appendix F-2: Additional Dispute Resolution Process

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

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

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

Appendix F-3: State Grievance/Complaint System

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

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

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

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

Appendix G-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*:

X	**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 California Department of Public Health (CDPH), Licensing and Certification (L&C) is responsible for the inspection and enforcement of licensed HHA/HAs providing services to waiver participants. The participating staff at L&C shall log in all reported events, investigate as appropriate, and provide a report to a Standing Committee comprised of staff from *State CMS* and L&C. Any disciplinary action taken by L&C on behalf of any participating provider shall first be discussed and agreed upon by the Standing Committee. L&C has made available, for distribution, a provider handbook that outlines performance expectations, reporting guidelines and the monitoring process. A complaint line poster with phone number is also distributed to providers.

In California, all individuals providing or monitoring health care are considered mandated reporters. A health practitioner or other mandated reporter, who has knowledge of or observes a participant in his/her professional capacity (or within the scope of his or her employment) whom he/she knows or reasonably suspects has been the victim of abuse, is required to report the known or suspected instance of abuse to a child or adult Protective Agency immediately or as soon as practically possible by telephone. The health practitioner or other mandated

reporter must also follow-up the verbal (telephonic) report to the Protective Agency by preparing and sending a *written* report of the suspected incident within 36 hours of receiving the information concerning the incident (Child Abuse and Neglect Reporting Act [Penal Code Sections 11164-11174.4] and all relevant California State and Federal Law and Regulations). The reporting requirement remains in effect even if the participant has expired, regardless of whether or not the possible abuse was a factor contributing to the participant's death and even if suspected abuse was discovered during an autopsy (Penal Code section 11166). Furthermore, any individual may report any critical event, incident or complaint concerning the health and safety of any participant at any time.

The CCSNL and/or the Care Coordinator documents all reported or observed critical events or incidents that may affect the health, safety and welfare of waiver participants. The Care Coordinator reports all incidents to the CCSNL and L&C as indicated. The CCSNL notifies the Care Coordinator of any critical event or incident referred directly to L&C. Examples of reportable critical events or incidents include: participant abuse (verbal, sexual, physical, or mental) or neglect; incidents posing an imminent danger to the participant; fraud or exploitation (including misuse of participant's funds and/or property); or an unsafe environment. At the time of enrollment, the CCSNL provides the applicant and Family Unit with both verbal and written instructions (in the form of the waiver enrollment/information packet). The instructions include how to report events or incidents that affect or can affect the health, safety and welfare of the waiver participant in accordance with 22 CCR §74743.

L&C has provided a complaint line notice and a contact number for use by all participating providers and the public. At the time of waiver enrollment, all staff, HHA/HAs and participants receive instructions that any critical event, incident or complaint may be reported to the CCSNL, Care Coordinator and/or directly to the staff at L&C. The CCSNL or Care Coordinator also uses the Complaint/Incident Intake Report to document and report concerns, problems, and incidents to ensure timely investigation and resolution.

The Complaint/Incident Intake Report is designed to document:

- The name and agency of the individual completing the report, if applicable
- The name and CCS number of the participant
- The telephone number of the participant and/or parent/legal guardian
- A description of the event or incident (the who, what, when and where)
- Who reported the event or incident
- The state and local agencies, the treating physician, and law enforcement who were notified, and when
- The plan of action to address/resolve the event or incident (who, what, when)
- The resolution and date resolved

The Care Coordinator and CCSNL document all reported incidents in the participant's file. If it is determined that reporting has not been completed according to statutory requirements, a Complaint/Incident Intake Report must be completed and forwarded to the appropriate agency.

The CCSNL updates the participant's case file to document L&C's actions and recommendations and the event/incident resolution. During an L&C investigation, the participant will continue to receive necessary services.

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 CCSNL and Care Coordinator are responsible for participant and Family Unit training and education. The CCSNL discusses and provides the waiver enrollment/information packet, to the participant/family, which includes a description of the different types of abuse, neglect, or exploitation; how to recognize if any of these occur; and whom to contact to report such events/incidents. The Care Coordinator provides health and welfare education and assessments when the F-CAP is developed and with each update. They also provide additional training as necessary.

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.

All reports concerning the care or services provided by the licensed HHA, HA, or CLHF shall be forwarded immediately to L&C for investigation.

The Complaint/Incident Intake Report is sent to the following agencies as required:

- Adult Protective Services (APS) (Ages 18-21)
- Child Protective Services (CPS) (Ages 0-17)
- County Welfare Department
- Local law enforcement

The Child/Adult Health and Welfare system (including local law enforcement) responds to critical events or incidents based on statutory requirements and their policies and procedures. (Penal Code §§11164-11174.5)

Reports of critical events or incidents made to L&C involving waiver providers are triaged to the appropriate professional licensing board. L&C has enforcement authority over HHAs, HAs, and CLHFs. L&C determines if the provider is in compliance with all applicable state and federal regulations and the H & S Code 1726 (HHA), 1748 (HA), and 1250(i) (CLHF).

L&C investigates when the waiver provider fails to:

- Report abuse or neglect of a waiver participant
- Notify the treating CCS physician of a change in the participant's condition, if the participant is harmed by the failure of this action
- Inform the participant and/or parent/legal guardian of the participant's "Patient Rights"
- Comply with the participant's "Patient Rights" as defined in 22 CCR §74743
- Complete the appropriate documentation and/or notify the participant's CCS physician of an incident
- Provide waiver services as described in the participant's F-CAP
- Provide adequate or appropriate evaluation of the participant's needs (e.g., weight loss not assessed)
- Provide adequate notification to the participant and/or parent/legal guardian when services or supplies are changed or terminated
- Act within their professional scope of practice (if verified, L&C will re-direct to licensing entity)
- Report suspected or verified medication misuse

Events/incidents referred to L&C are tracked by L&C and *State CMS* (Standing Committee) to ensure adequate response and resolution. The CCSNL or Care Coordinator follow up with the participant and/or Family Unit to make sure the issue has been resolved and there is no longer any risk to the participant's health, safety and welfare. If the issue is not resolved within 10 days, the CCSNL, Care Coordinator, *State CMS,* and L&C collaboratively develop and implement an alternative plan for resolution.

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.

State CMS partners with L&C in the oversight operation of reporting and responding to critical incidents or events and communicates at least quarterly, or more often, as needed, through the Standing Committee on the oversight activities.

In the event of involvement of the Child/Adult Health and Welfare system, the CCSNL and/or Care Coordinator continues to monitor the participant's health and safety to ensure the issues have been resolved.

Appendix G 2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints or Seclusion *(select one):*

X	The State does not permit or prohibits the use of restraints or seclusion. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:
	State CMS staff, the CCSNL and the Care Coordinator are responsible for ongoing monitoring and ensuring the health, safety and welfare of waiver participants including ensuring that restraints or seclusion are not utilized under any circumstances. This is accomplished through the initial interview with the participant and parent/legal guardian, home visits and/or telephone contact with participants, and/or Family Unit, waiver providers, Special Care Centers (SCCs) and CCS physicians. If the Care Coordinator, waiver provider or the CCSNL observe or learn that restraints or seclusion are being used, a Complaint/Incident Intake Report must be completed. Use of restraints or seclusion by any waiver provider is immediately referred to L&C for investigation and reporting of findings. *State CMS* partners with L&C in the oversight of reporting and responding to use of restraints or seclusion and communicates at least quarterly, or more often, as needed, through the Standing Committee on the oversight activities.
○	The use of restraints or seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii:

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

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

b. Use of Restrictive Interventions

X	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:
	State CMS staff, the CCSNL and the Care Coordinator are responsible for ongoing monitoring and ensuring the health, safety and welfare of waiver participants including ensuring that restrictive interventions are not utilized under any circumstances. Examples of restrictions are those that limit the participant's movement or access to other individuals, locations, or activities. Restrictive interventions also include those that restrict the participant's rights or other adverse techniques that are designed to modify a participant's behavior. This is accomplished through the initial interview with the participant and parent/legal guardian, home visits and/or telephone contact with participants, and/or Family Unit, waiver providers, SCCs and CCS physicians. If the Care Coordinator, waiver provider or the CCSNL observe or learn that restrictive interventions are being used, a Complaint/Incident Intake Report must be completed. Use of restrictive interventions by any waiver provider is immediately referred to L&C for investigation and reporting of findings. *State CMS* partners with L&C in the oversight of reporting and responding to use of restrictive interventions and communicates at least quarterly, or more often, as needed, through the Standing Committee on the oversight activities.
○	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-a-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-3: Medication Management and Administration

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

a. Applicability. Select one:

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

b. Medication Management and Follow-Up

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

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

c. Medication Administration by Waiver Providers

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

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

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

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

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

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: **Health and Welfare**
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

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

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

Performance Measure: **HEALTH AND WELFARE ~reporting**	**Number and percent of critical incidents, specifically occurrences of abuse, neglect and exploitation, reported within required timeframe** Numerator: number of critical incidents reported in timeframe Denominator: number of critical incidents reported		
Data Source 1 ***[e.g. – examples cited in IPG]***	***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)*
Record review – off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	95%
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

State:	
Effective Date	

Data Source 2 ***[e.g. – examples cited in IPG]***	***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)*
Operating agency performance monitoring	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	X *Other: Specify:*	**X** *Annually*	95%
	CDPH Licensing and Certification (L&C)	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
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)*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

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Performance Measure: **HEALTH AND WELFARE ~remediation action**	**Number and percent of critical incidents, specifically occurrences of abuse, neglect and exploitation, for which necessary corrective actions were taken** Numerator: number of critical incidents with corrective action taken Denominator: number of critical incidents reported		
Data Source 1 ***[e.g. – examples cited in IPG]***	***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)*
Record review – off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	95%
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Source 2 ***[e.g. – examples cited in IPG]***	***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)*
Operating agency performance monitoring	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	X *Other: Specify:*	**X** *Annually*	95%
	CDPH Licensing and	☐ *Continuously and*	☐ *Stratified:*

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Effective Date	

	Certification (L&C)	*Ongoing*	*Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
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)*	
	X *State Medicaid Agency*	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	**X** *Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Performance Measure: **HEALTH AND WELFARE ~provider training**	**Number and percent of waiver providers who have completed waiver provider training in which health and safety requirements, including prevention, are discussed** Numerator: number of providers who have completed training Denominator: a representative sample of providers		
Data Source [e.g. – examples cited in IPG]	***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)*
Record review – off-site	**X** *State Medicaid Agency*	*☐ Weekly*	*☐ 100% Review*
	☐ Operating Agency	*☐ Monthly*	**X** *Less than 100% Review*
	X *Sub-State Entity*	*☐ Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ Other: Specify:	**X** *Annually*	95%
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other:

State:	
Effective Date	

			Describe
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)*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure: **HEALTH AND WELFARE ~monitoring and prevention**	**Number and percent of F-CAPs that show documentation of monitoring of environmental assessments, family social evaluations, and information provided regarding abuse, neglect and exploitation** Numerator: number of F-CAPs with documentation Denominator: a representative sample of F-CAPs		
Data Source [e.g. – examples cited in IPG]	***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)*
Record review – off-site	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	X *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	95%
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

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Effective Date	

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)*	
	X *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	**X** *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

a.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

b.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.*

State CMS provides ongoing monitoring of participant health and welfare related activities, including if:

- An F-CAP does not meet requirements for continuous monitoring of environmental assessments, family social evaluations or information regarding abuse, neglect and exploitation
- Inappropriate or untimely action occurs in response to a report (abuse, neglect, exploitation, critical incident or event, etc.)

Upon discovery, *State CMS*, within 15 working days, contacts the participating county(s) to:

1. Review the data
2. Determine the reason for non-compliance
3. If appropriate, develop a corrective action plan with a timeline that will achieve remediation within 15 working days from the date the county was notified by the CMS Branch, where possible

If remediation is not achievable within 15 working days, a note from the CCS County, or *State CMS*, documents the reason for the delay, the manager's approval, and the timeframe for remediation.

Documentation (using case notes in CMSNet and entries in the PFC access

database) of the steps noted above also include any suggestions for preventing similar failures in the future, i.e. suggested system or process changes. *State CMS* follows up with the CCS county to ensure that the corrective action plan was completed within the specified timeframe.

Should a participating CCS county discover non-compliance, as it relates to health and welfare sub-assurances, it is the responsibility of the CCSNL to begin the remediation process within 2-5 working days (or sooner, to the extent mandated by California law), including all steps noted above, as appropriate to the sub-assurance in question. [Child Abuse and Neglect Reporting Act, California Penal Code (PC) § 11164 through 11174.3 P.C. states that a mandated reporter shall report to the licensing agency immediately or as soon as possible and provide a written report within 36 hours of receiving information concerning the incident.]

State CMS uses the systemic quality improvement strategy, defined in Appendix H, to monitor compliance and success of the program across all performance measures.

b.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)*
	X *State Medicaid Agency*	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	X *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	**X** *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.

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

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

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Appendix H: Systems Improvement

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

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

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

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a State describes:

(1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances;
(2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and
(3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

H.1 Systems Improvement

a.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.

State CMS waiver staff monitors all issues related to the Quality Improvement Strategy (QIS). This includes all QI issues discovered and remediation that has occurred. Information is gathered in a variety of ways:

- Monthly calls with the County CCS staff (sub-state entities)
- CCSNL and Care Coordinator conversations with participants/families
- Quarterly calls with agency waiver providers
- Quarterly meetings with L&C
- County and provider site visits
- Data reports from CMSNet and PFC database
- Forms submitted by CCSNL for review (LOC & F-CAP)
- Communication with independent evaluators and stakeholders
- Other communications as issues arise

State CMS staff meets quarterly for QIS to:

- Discuss quality assurance feedback received through methods above
- Identify trends in quality assurance issues
- Prioritize issues for analysis and systemic remediation
- Assign individual members to take lead roles for various QIS responsibilities
- Compile a list of questions and advisory topics for further discussion at subsequent meetings with county staff, agency waiver providers, stakeholders as appropriate

Annually, *State CMS* staff determines to what extent each waiver assurance has been met during the reporting period and measures it against goals and assesses trends. Staff activities include:

- Aggregating the data collected for each performance measure through reports from the PFC database, provider files, MIS-DSS, participant files, CMSNet case notes, documentation from L&C
- Analyzing the resulting aggregated data to determine system changes needed

The systemic improvement process includes assessing trends, defining priorities and identifying strategies for improvement as a result of analysis of performance measure discovery and remediation information. Staff activities include:

- Prioritizing system changes based on program goals and risk analysis.
- Developing strategies for improvement based on:
  - Assessment of the successes and opportunities for improvement in current methodology including determination of the cause(s) of the failures
    - When appropriate, collaborate with County CCS staff, waiver providers, and other stakeholders

- Review of other systems (comparable waivers in this state and other states) that have had similar issues and the remediation actions taken by them
- Developing systemic remediation plans to address each system issue

The systemic remediation plans have the primary goal of developing and implementing methods to resolve current problems and prevent future failures. The *State CMS* waiver staff ensures that systemic improvements are communicated and properly implemented.

a.ii

System Improvement Activities	***Responsible Party*** *(check each that applies)*	***Frequency of monitoring and analysis*** *(check each that applies)*
	X *State Medicaid Agency*	**X** *Weekly*
	☐ *Operating Agency*	**X** *Monthly*
	X *Sub-State Entity*	**X** *Quarterly*
	☐ *Quality Improvement Committee*	**X** *Annually*
	☐ *Other: Specify:*	☐ *Other: Specify:*

b.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, and how the results of the changes and the assessment are communicated (and with what frequency) to stakeholders, including participants, families, providers, agencies and other interested parties. If applicable, include the State's targeted standards for systems improvement.

State CMS waiver staff track actions and outcomes from system changes through amendments, waiver renewal and policy and data collection changes.

System changes are communicated to county staff, agency waiver providers, participants, referring providers, and stakeholders through a variety of methods including:

- Program Notices and CCS Numbered Letters
- Website
- Monthly calls with county staff
- Quarterly calls with agency waiver providers and other stakeholders
- CCSNL and Care Coordinator conversations with participants/families
- County staff communication to referring providers
- Stakeholder Listserv

State CMS communicates with waiver county staff and providers to acquire feedback on system changes that have been made and whether or not they have been effective. Communication includes:

- Monthly calls with county staff
- Quarterly calls with agency waiver providers
- Site visits to county offices
- Site visits to agency waiver providers

County staff and agency waiver providers also contact *State CMS* on an ongoing basis to provide feedback and as issues arise.

State CMS Staff meet quarterly for QIS to:

- Discuss feedback on system changes acquired using the above methods
- Prioritize areas for further system modifications if necessary
- Assign individual members to take lead roles for various QIS responsibilities
- Compile a list of questions and advisory topics for further discussion at subsequent meetings with county staff, agency waiver providers, stakeholders as appropriate

b.ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Annually, *State CMS* will evaluate the effectiveness of the Quality Improvement Strategy described above. This will include review of:

- Appendix H as well as Quality Assurance sections of Appendices A, B, C, D, G and I
- Most recent CMS 372 report
- Quarterly CMS 64 reports
- Annual assurance report (from database)
- Remediation (including feedback from stakeholders etc.)
- System changes made that year (including feedback…)
- Data collection methods and integrity
- Methods of communication/disseminating information
- Policy: program notices, manuals…

Revisions to the QIS will be made as appropriate based on the annual review described above.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

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

Pediatric Palliative Care Waiver providers are subject to the requirement of the Single Audit Act (31 U.S.C. 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104-146). Payments for waiver services are made through the approved California Medicaid Management Information System (CA-MMIS). The California Department of Health Care Services (DHCS) Fiscal Intermediary and Contracts Oversight Division (FICOD) administers the Medi-Cal claiming system and manages the State's third party fiscal intermediary contract with the current fiscal intermediary (FI).

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

The DHCS Audits and Investigations (A&I) Division is responsible for ensuring the fiscal integrity and medical necessity of Medi-Cal program services. All claims submitted by waiver and state plan providers are subject to random review regardless of provider type, specialty, or service rendered. The A&I Division verifies that claims selected have sufficient documentation to approve the claim for payment. Providers are notified if a claim requires additional documentation before approval for payment. Failure to comply with the request for additional documentation may result in suspension from the Medi-Cal program, pursuant to Welfare and Institutions Code (W & I Code) §14124.2. The A&I Division has three branches that conduct reviews using various methodologies to ensure program integrity and the validity of claims for reimbursement.

The A&I Medical Review Branch (MRB) performs essential medical reviews of non-institutional providers. Providers may also be subject to a more comprehensive review on a weekly basis known as a pre-checkwrite review. This review is based on a set of criteria, such as irregular billing patterns, designed to identify potential fraud or abuse. Providers selected for this more comprehensive review may 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 which include performing field reviews on new Medi-Cal providers and providers undergoing re-enrollment. MRB is charged with bringing closure to sanctioned providers through audits designed to quantify the abuse, settlement agreement, or permissive suspensions (exclusions) from the Medi-Cal program. Failure to comply with any request by A&I staff for documentation may result in administrative sanctions, including suspension from the Medi-Cal program, pursuant to W&I Code §14124.2.

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

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

The A&I Investigations Branch (IB) conducts investigations of suspected Medi-Cal beneficiary fraud as well as preliminary investigations of provider fraud. IB is also responsible for coordinating provider fraud referrals to the state Department of Justice (DOJ) and Federal Bureau of Investigation. Suspected fraud or abuse identified through any audit or investigation process is referred to the DOJ via the IB. IB and MRB coordinate the placing of administrative sanctions on providers with substantiated evidence of fraud. IB serves as DHCS's principal liaison with outside law enforcement and prosecutorial entities on Medi-Cal fraud.

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.

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

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

Performance Measure: **FINANCIAL ~claims**	**Number and percent of claim lines paid in accordance with the participant's authorized services** Numerator: number of claim lines paid according to authorization Denominator: a representative sample of claim lines		
Data Source [e.g. – examples cited in IPG]	***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)*
Financial records (including expenditures)	**X** *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	**X** *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	**X** *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	**X** *Annually*	95%
		☐ *Continuously and*	☐ *Stratified:*

State:	
Effective Date	

		Ongoing	*Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
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)*	
	X *State Medicaid Agency*	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	**X** *Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

a.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

b.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.*

State CMS provides ongoing monitoring of participant financial accountability related activities, including if:

- Claims were not CODED in accordance with the methodology defined in the waiver and the individual SAR
- Claims were not PAID in accordance with the methodology defined in the waiver and the individual SAR

Upon discovery, *State CMS*, within 15 working days, contacts the participating county(s) to:

1. Review the data
2. Determine the reason for non-compliance
3. If appropriate, develop a corrective action plan with a timeline that will achieve

remediation within 15 working days from the date the county was notified by the CMS Branch, where possible

If remediation is not achievable within 15 working days, a note from the CCS County, or *State CMS*, documents the reason for the delay, the manager's approval, and the timeframe for remediation.

Documentation (using case notes in CMSNet and entries in the PFC access database) of the steps noted above is also include any suggestions for preventing similar failures in the future, i.e. suggested system or process changes. *State CMS* follows up with the CCS county to ensure that the corrective action plan was completed within the specified timeframe.

Should a participating CCS county discover non-compliance, as it relates to financial accountability sub-assurances, it is the responsibility of the CCSNL to begin the remediation process within 15 working days, including all steps noted above, as appropriate to the sub-assurance in question.

State CMS uses the systemic quality improvement strategy, defined in Appendix H, to monitor compliance and success of the program across all performance measures.

b.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)*
	X *State Medicaid Agency*	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	X *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		X *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.

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

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 I-2: Rates, Billing and Claims

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

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

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

- 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 equivalent Medicare service rate in California
- Review of standards of care prescribed under state statutes and regulations and identification of service providers
- Identification of cost factors
- Identification of at least seven states offering a similar type of service, and determining the average rate of reimbursement
- Market survey and identification of rates of reimbursement by governmental and non-governmental third-party payers for the same or similar services

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

DHCS may use any of the four methods listed below to establish rates for waiver services, which are based on provider type and the service provided:

- The adoption of published Medi-Cal State Plan or other State Department service rates for similar services
- Hourly rates established locally by county governments/authorities
- Annual rate studies
- 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

The list below describes the rate methodology used to establish payment rates for DHCS PFC Waiver services.
Expressive Therapy: Adoption of Florida pediatric palliative care waiver rate.
Care Coordination, Family Counseling, Respite Care, Family Training, and Pain and Symptom Management, Personal Care: Adoption of published service rates for comparable state plan services.

Rates paid for PFC 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.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The CCSNL is responsible for prior authorization of all PFC Waiver services and verifies that the requested services are in accordance with the participant's Family-Centered Action Plan (F-CAP). Waiver service providers are responsible for submitting a Service Authorization Request (SAR) to CCS for prior authorization of all PFC Waiver services. Claims for services are paid after the service is rendered.

PFC Waiver providers submit claims to the FI for services rendered using either a CMS 1500 or UB 04 claim form. These claims are subject to all established requirements for processing directly through the CA-MMIS system. The FI adjudicates claims for services, resulting in one of four possible actions:

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

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

c. Certifying Public Expenditures *(select one)*:

○	**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 (*check each that applies*):	
	☐	**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.*)
X	**No**. State or local government agencies do not certify expenditures for waiver services.	

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Claims for waiver services must meet CA-MMIS requirements for processing, including program edits and audits.

Completed claims processed through CA-MMIS are run against system edits and audits to verify:

- Services are prior authorized
- Satisfactory Medi-Cal eligibility status
- Participant is enrolled in the waiver
- Provider is an enrolled Medi-Cal HCBS waiver provider
- Claim is not a duplicate
- Claim is paid according to published rates or CMS negotiated rate

The CCSNL contacts waiver participants and waiver providers by letter or telephone at least annually to ensure that services were provided and in accordance with the F-CAP. Should a discrepancy occur, the CCSNL reports it to *State CMS* for investigation.

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-3: Payment

a. Method of payments — MMIS *(select one)*:

X	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) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐	The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
X	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
☐	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

X	**No**. The State does not make supplemental or enhanced payments for waiver services.
○	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (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.

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

○	**Yes.** State or local government providers receive payment for waiver services. Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish. *Complete item I-3-e.*
X	**No**. State or local government providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to State or Local Government Providers**. Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

○	The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
○	The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
○	The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

X	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
○	Providers 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.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○	**Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
X	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

○	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
X	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
X	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

X	**Appropriation of State Tax Revenues to the State Medicaid agency**
☐	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the 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:

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. *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:
X	**Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds . *Select one:*

X	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-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

X	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
○	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

○	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
X	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

X	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(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)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. The State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

X	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (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

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:	Hospital						
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 (Column 7 less Column 4)**
1	$26,067	$53,627	$79,693	$437,134	$45,023	$482,157	$402,464
2	$26,690	$55,236	$81,926	$450,248	$46,374	$496,622	$414,696
3	$27,364	$56,893	$84,257	$463,756	$47,765	$511,521	$427,264
4	$27,867	$58,600	$86,467	$477,668	$49,198	$526,866	$440,400
5	$29,257	$60,358	$89,615	$491,998	$50,674	$542,672	$453,058

State:	
Effective Date	

Appendix J-2 - Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	1800		
Year 2	1800		
Year 3	1800		
Year 4 (renewal only)	1800		
Year 5 (renewal only)	1800		

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

The estimated average length of stay was taken from the Colorado CHI PACC waiver, which was determined based on the following method. The estimated average length of stay was determined by analysis of data from the CHI PACC program, Colorado State death statistics for the population that will be served under the waiver, and national hospice statistics. This information combined with the experience gained from operating the Children's Extensive Support Waiver (number 4180.90.01), which serves a similar target group; the average length of stay was determined to be 330 days.

This value remains for the renewal since during the first waiver year no participants were enrolled until the 4th quarter. This means that the first CMS 372 Report did not cover a full year and so the average length of stay calculated there is not representative.

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 derivation is comprised of the following elements:

- Waiver slots – Slots for the renewal remain 1800 based on the 3rd year of the original waiver.
- Expected utilization - Utilization was estimated by a team of medical professionals with expertise in pediatric palliative care. Estimates were created for both the number of participants expected to require the service each year and for how many units on average each participant would utilize.
- Rates - Current California rates are used for all waiver services. Current rate for Personal care as an added service.

An inflation rate of 3% is used for all factors to project waiver renewal years 2012-2016.

This method remains for the renewal since during the first waiver year no participants were enrolled until the 4th quarter. This means that the first CMS 372 Report did not cover a full year and so the Factor calculations there are not representative.

New service: Personal Care is being added to fulfill an unmet need for clients to receive assistance with bathing and grooming through the PFC Hospice agency when they are not already receiving this service through EPSDT. Personal care also provides support for caregivers through light housekeeping. Personal care is expected to increase satisfaction with the waiver and support families in maintaining a safe and clean home environment. The addition of this benefit would ensure that an approved PFC hospice agency can provide the complete spectrum of palliative care services to the children enrolled in PFC. Hospice agencies are currently reimbursed on a per-diem basis for this benefit for individuals enrolled in hospice, which excludes children enrolled in PFC.

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:

D' was estimated based on total ancillary paid claims for the time period during which the case study group members were not residing in institutional care, in calendar year 2006. Total ancillary costs were averaged for the case study group and then projected forward for the initial waiver years based on the same inflation index utilized in factor D.

This method remains for the renewal since during the first waiver year no

participants were enrolled until the 4th quarter. This means that the first CMS 372 Report did not cover a full year and so the Factor calculations there are not representative. Values for the renewal years were adjusted from Waiver year 3 values using the inflation rate of 3%.

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:

G was estimated based on total acute institution paid claims for the case study group members in calendar year 2006. Total acute institution costs were averaged for the case study group and then projected forward for the initial waiver years based on the same inflation index utilized in factor D. This method remains for the renewal since during the first waiver year no participants were enrolled until the 4th quarter. This means that the first CMS 372 Report did not cover a full year and so the Factor calculations there are not representative. Values for the renewal years were adjusted from Waiver year 3 values using the inflation rate of 3%.

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:

G' was estimated based on total ancillary paid claims for the time period during which the case study group members were residing in acute institutions, in calendar year 2006. Total ancillary acute institution costs were averaged for the case study group and then projected forward for the initial waiver years based on the same inflation index utilized in factor D. This method remains for the renewal since during the first waiver year no participants were enrolled until the 4th quarter. This means that the first CMS 372 Report did not cover a full year and so the Factor calculations there are not representative. Values for the renewal years were adjusted from Waiver year 3 values using the inflation rate of 3%.

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

X	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. **Estimate of Factor D – Non-Concurrent Waiver**. Complete the following table for each waiver year

Renewal Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Care Coordination - Start Up	One Time	720	1	$1,030	$741,600
Care Coordination - monthly maintenance	Months	1800	12	$236	$5,097,600
Care Coordination - supplemental hourly	Hours	360	240	$47	$4,060,800
Family Training, Agency RN	Hours	558	25	$47	$655,650
Family Training, Indv RN	Hours	36	25	$37	$33,300
Family Counseling	One Time	1800	22	$52	$2,059,200
Home Respite, Agency RN alone	15 Minutes	90	1440	$10	$1,296,000
Home Respite, Agency RN supervise	15 Minutes	1260	120	$10	$1,512,000
Home Respite, Agency LVN	15 Minutes	630	1440	$8	$7,257,600
Home Respite, Agency HHA	15 Minutes	630	1440	$5	$4,536,000
Home Respite, Indv RN alone	15 Minutes	90	1440	$8	$1,036,800
Home Respite, Indv RN supervise	15 Minutes	90	120	$8	$86,400
Home Respite, Indv LVN	15 Minutes	90	1440	$6	$777,600
Out of Home Respite, CLHF U1	Days	90	15	$94	$126,900
Out of Home Respite, CLHF U2	Days	90	15	$370	$499,500
Out of Home Respite, CLHF U3	Days	90	15	$505	$681,750
Expressive Therapy	Hours	1440	240	$36	$12,441,600

Pain and Symptom Management	Hours	900	100	$42	$3,780,000
Personal Care	Hours	126	100	$19	$239,400
GRAND TOTAL:					$46,919,700
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1800
FACTOR D (Divide grand total by number of participants)					$26,067
AVERAGE LENGTH OF STAY ON THE WAIVER					330 days

Renewal Waiver Year: Year 2					
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Care Coordination - Start Up	One Time	720	1	$1,061	$763,920
Care Coordination - monthly maintenance	Months	1800	12	$243	$5,248,800
Care Coordination - supplemental hourly	Hours	360	240	$48	$4,147,200
Family Training, Agency RN	Hours	558	25	$48	$669,600
Family Training, Indv RN	Hours	36	25	$38	$34,200
Family Counseling	One Time	1800	22	$54	$2,138,400
Home Respite, Agency RN alone	15 Minutes	90	1440	$11	$1,425,600
Home Respite, Agency RN supervise	15 Minutes	1260	120	$11	$1,663,200
Home Respite, Agency LVN	15 Minutes	630	1440	$8	$7,257,600
Home Respite, Agency HHA	15 Minutes	630	1440	$5	$4,536,000
Home Respite, Indv RN alone	15 Minutes	90	1440	$8	$1,036,800
Home Respite, Indv RN supervise	15 Minutes	90	120	$8	$86,400
Home Respite, Indv LVN	15 Minutes	90	1440	$6	$777,600
Out of Home Respite, CLHF U1	Days	90	15	$97	$130,950
Out of Home Respite, CLHF U2	Days	90	15	$381	$514,350
Out of Home Respite, CLHF U3	Days	90	15	$520	$702,000

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Renewal Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Expressive Therapy	Hours	1440	240	$37	$12,787,200
Pain and Symptom Management	Hours	900	100	$43	$3,870,000
Personal Care	Hours	126	100	$20	$252,000
GRAND TOTAL:					$48,041,820
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1800
FACTOR D (Divide grand total by number of participants)					$26,690
AVERAGE LENGTH OF STAY ON THE WAIVER					330 days

Renewal Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Care Coordination - Start Up	One Time	720	1	$1,093	$786,960
Care Coordination - monthly maintenance	Months	1800	12	$250	$5,400,000
Care Coordination - supplemental hourly	Hours	360	240	$50	$4,320,000
Family Training, Agency RN	Hours	558	25	$50	$697,500
Family Training, Indv RN	Hours	36	25	$39	$35,100
Family Counseling	One Time	1800	22	$56	$2,217,600
Home Respite, Agency RN alone	15 Minutes	90	1440	$11	$1,425,600
Home Respite, Agency RN supervise	15 Minutes	1260	120	$11	$1,663,200
Home Respite, Agency LVN	15 Minutes	630	1440	$8	$7,257,600
Home Respite, Agency HHA	15 Minutes	630	1440	$5	$4,536,000
Home Respite, Indv RN alone	15 Minutes	90	1440	$9	$1,166,400
Home Respite, Indv RN supervise	15 Minutes	90	120	$9	$97,200
Home Respite, Indv LVN	15	90	1440	$7	$907,200

State:	
Effective Date	

Renewal Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
	Minutes				
Out of Home Respite, CLHF U1	Days	90	15	$100	$135,000
Out of Home Respite, CLHF U2	Days	90	15	$392	$529,200
Out of Home Respite, CLHF U3	Days	90	15	$536	$723,600
Expressive Therapy	Hours	1440	240	$38	$13,132,800
Pain and Symptom Management	Hours	900	100	$44	$3,960,000
Personal Care	Hours	126	100	$21	$264,600
GRAND TOTAL:					$49,255,560
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1800
FACTOR D (Divide grand total by number of participants)					$27,364
AVERAGE LENGTH OF STAY ON THE WAIVER					330 days

Renewal Waiver Year: Year 4 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Care Coordination - Start Up	One Time	720	1	$1,126	$810,720
Care Coordination - monthly maintenance	Months	1800	12	***$356.26**	***$7,695,216.00**
Care Coordination - supplemental hourly	Hours	360	240	$51	$4,406,400
Family Training, Agency RN	Hours	558	25	***$67.44**	***$940,788.00**
Family Training, Indv RN	Hours	36	25	$40	$36,000
Family Counseling	One Time	1800	22	$57	$2,257,200
Home Respite, Agency RN alone	15 Minutes	90	1440	$11	$1,425,600
Home Respite, Agency RN supervise	15 Minutes	1260	120	$11	$1,663,200
Home Respite, Agency LVN	15 Minutes	630	1440	$8	$7,257,600

State:	
Effective Date	

Renewal Waiver Year: Year 4 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Home Respite, Agency HHA	15 Minutes	630	1440	$5	$4,536,000
Home Respite, Indv RN alone	15 Minutes	90	1440	$9	$1,166,400
Home Respite, Indv RN supervise	15 Minutes	90	120	$9	$97,200
Home Respite, Indv LVN	15 Minutes	90	1440	$7	$907,200
Out of Home Respite, CLHF U1	Days	90	15	$103	$139,050
Out of Home Respite, CLHF U2	Days	90	15	$404	$545,400
Out of Home Respite, CLHF U3	Days	90	15	$552	$745,200
Expressive Therapy	Hours	1440	240	***$45**	***$15,552.000.00**
Pain and Symptom Management	Hours	900	100	***$67.44**	***$6,069,600.00**
Personal Care	Hours	126	100	$21	$264,600
GRAND TOTAL:					$50,160,420
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1800
FACTOR D (Divide grand total by number of participants)					$27,867
AVERAGE LENGTH OF STAY ON THE WAIVER					330 days

Renewal Waiver Year: Year 5 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Care Coordination - Start Up	One Time	720	1	$1,159	$834,480
Care Coordination - monthly maintenance	Months	1800	12	***$356.26**	***$7,695,216.00**
Care Coordination - supplemental hourly	Hours	360	240	$53	$4,579,200
Family Training, Agency RN	Hours	558	25	***$67.44**	***$940,788.00**
Family Training, Indv RN	Hours	36	25	$41	$36,900
Family Counseling	One	1800	22	$59	$2,336,400

State:	
Effective Date	

Renewal Waiver Year: Year 5 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
	Time				
Home Respite, Agency RN alone	15 Minutes	90	1440	$12	$1,555,200
Home Respite, Agency RN supervise	15 Minutes	1260	120	$12	$1,814,400
Home Respite, Agency LVN	15 Minutes	630	1440	$9	$8,164,800
Home Respite, Agency HHA	15 Minutes	630	1440	$5	$4,536,000
Home Respite, Indv RN alone	15 Minutes	90	1440	$9	$1,166,400
Home Respite, Indv RN supervise	15 Minutes	90	120	$9	$97,200
Home Respite, Indv LVN	15 Minutes	90	1440	$7	$907,200
Out of Home Respite, CLHF U1	Days	90	15	$106	$143,100
Out of Home Respite, CLHF U2	Days	90	15	$416	$561,600
Out of Home Respite, CLHF U3	Days	90	15	$569	$768,150
Expressive Therapy	Hours	1440	240	***$45.00**	***$15,552.000.00**
Pain and Symptom Management	Hours	900	100	***$67.44**	***$6,069,600.00**
Personal Care	Hours	126	100	$22	$277,200
GRAND TOTAL:					$52,662,780
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1800
FACTOR D (Divide grand total by number of participants)					$29,257
AVERAGE LENGTH OF STAY ON THE WAIVER					330 days

Proposed revision is **bolded** and marked with an asterisk (*).

State:	
Effective Date	