DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **09-023**

2. STATE: CALIFORNIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
OCTOBER 1, 2009

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
SOCIAL SECURITY ACT 1915(I)

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 $ 88,100,000
b. FFY 2010 $ 112,500,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

ATTACHMENT 3.1-c pages 1-63
ATTACHMENT 4.19-B pages 64-75

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

NONE

10. SUBJECT OF AMENDMENT:
1915(i) – HOME AND COMMUNITY-BASED SERVICES

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Toby Douglas

14. TITLE:
Chief Deputy Director

15. DATE SUBMITTED: 12/30/09 (original), 9/30/10 (amended)

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.3.26
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

DHCS

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

DAVID MAXWELL-JOLLY
Director

ARNOLD SCHWARZENEGGER
Governor

SEP 30 2010

Ms. Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA. 94103-6707

Dear Ms. Nagle:

The California Department of Health Care Services (DHCS) is formally submitting responses to your March 26, 2010, letter transmitting the Centers for Medicare & Medicaid Services' (CMS') request for additional information (RAI) regarding the DHCS State Plan Amendment (SPA) 09-023 submitted on December 30, 2009, for implementing Section 1915(i) authority for home and community-based services under the State Plan. The 1915(i) SPA is California's first State Plan Amendment providing home and community-based services.

DHCS has been working closely with Ellen Blackwell and has revised the proposed amendment pages as requested. Please find the following enclosures in response to the RAI:

- 1915(i) State Plan application, Attachment 3.1-C
- Revised State Plan pages for reimbursement, Attachment 4.19-B pages 64-75
- Formal response to CMS' RAI questions

We appreciate CMS' technical assistance and guidance on our initial 1915(i) SPA.

Please contact Paul Miller, Chief, Long-Term Care Division, at (916) 440-7534, or by email at Paul.Miller@dhcs.ca.gov, if you have any questions.

Sincerely,

Toby Douglas, Chief Deputy Director
Health Care Programs

Enclosures

cc: see next page

cc: Ms. Ellen Blackwell
Division of Community and Institutional Services
U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, MS S2-11-07
Baltimore, MD 21244-1850

Ms. Kathy Poisal
U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
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Ms. Cynthia Nanes
U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA. 94103-6707

Ms. Beverly Binkier
U.S. Department of Health & Human Services
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90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA. 94103-6707

Ms. Rita Walker, Deputy Director
Community Operations Division
Department of Development Services
1600 Ninth Street, Room 320, MS 3-9
Sacramento, CA 94244-2020

Mr. Jim Knight, Chief
Waiver Monitoring Section
Department of Developmental Services
1600 Ninth Street, Room 320, MS 3-9
Sacramento, CA 94244-2020

Mr. Paul Miller, Chief
Long-Term Care Division
Department of Health Care Services
1501 Capitol Avenue, MS 0018
Sacramento, CA 95899-7417

Schedule of Maximum Allowance

The link to the SMA's is http://files.medi-cal.ca.gov/pubsdoco/rates/rateshome.asp

The SMA's for the services in the 1915(i) spa are;

For ADHC's

Description	Rate *
Comprehensive multidisciplinary evaluation	$ 80.08
Day care services, adult; per diem	76.27
Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	64.83

For Home Health Aides, the rate is $45.75

Work Activity Program (WAP)
Service Code 954
Upper Limits for WAP
Effective 7/1/2006

Small vendors:	0 to 30 consumers	$58.86 per consumer per day
Medium vendors:	31 to 100 consumers	$42.30 per consumer per day
Large vendors:	101 or more consumers	$31.50 per consumer per day
Statewide average:	Temporary Rate	$35.29 per consumer per day

Supported Employment Programs (SEP)
Service Codes 950 & 952
Effective 10/1/2008

The hourly rate shall be $30.82 as per Welfare and Institutions Code 4860 (a) (1).

COMMUNITY-BASED DAY PROGRAMS AND IN-HOME RESPITE AGENCIES

ALLOWABLE RANGE OF RATES AND TEMPORARY PAYMENT RATES

2007/08 FISCAL YEAR

Effective January 1, 2008

Service Category	Staff Ratio	Lower Limit	Upper Limit	Temporary Payment Rate
Daily Rates				
Activity Center (505)	1:8	$26.83	$46.91	$36.39
	1:7	28.52	46.20	36.54
	1:6	32.68	56.76	45.09
Adult Dev. Center (510)	1:4	36.14	66.94	53.86
	1:3	45.43	69.22	58.87
Behavior Management (515)	1:3	49.97	83.49	72.42
Hourly Rates				
Independent Living (520)	1:3	10.64	16.54	14.31
	1:2	17.45	22.68	20.66
	1:1	22.42	43.00	31.62
Social Recreation (525)	1:10	13.12	24.74	16.36
Infant Development (805)	1:3	28.66	48.34	38.72
	1:2	42.58	73.65	59.17
	1:1	60.07	108.05	78.29
In-Home Respite (862)	1:1	14.16	20.68	17.53
In-Home Respite (862) (eff. 1/1/08)	1:1	14.75	21.27	18.12

DEPARTMENT OF DEVELOPMENTAL SERVICES
1600 NINTH STREET, Room 320, MS 3-9
SACRAMENTO, CA 95814
TDD 654-2054 (For the Hearing Impaired)
(916) 654-1958

December 18, 2008

TO: REGIONAL CENTER DIRECTORS

SUBJECT: COMMUNITY CARE FACILITY (CCF) RATES EFFECTIVE JANUARY 1, 2009

The Fiscal Year (FY) 2008-2009, budget for Alternative Residential Model (ARM), CCFs, includes a rate increase to reflect the impact of the federal Social Security Income cost of living increase, effective January 1, 2009. However, the FY 2008-2009, budget does **not** allow for the pass through of any Social Security Income/State Supplemental Program (SSI/SSP) increase that becomes effective January 1, 2009. Therefore, the estimated $33 increase in SSI/SSP for Board and Care is to be used as an offset to the regional center supplement portion of the Alternative Residential Model (ARM) rate. Thus, the overall rate to be paid to ARM service level 2, 3, and 4 A-I providers will not change effective January 1, 2009. The enclosed CCF rate chart has been updated to reflect the impact of the SSI/SSP increase.

The Personal and Incidental expenses associated with the January 1, 2009, SSI/SSP payment standard increased from $121.00 to $125.00.

If you have questions concerning the SSI/SSP CCF payment standard, please contact Shelton Dent, Residential Services & Monitoring Branch, at (916) 654-2732.

Sincerely,

Original signed by

RITA WALKER
Deputy Director
Community Operations Division

Enclosure

DEPARTMENT OF DEVELOPMENTAL SERVICES
COMMUNITY CARE FACILITY RATES
EFFECTIVE JANUARY 1, 2009

Service Level	Monthly Payment Rate Per Consumer Effective **1/01/2009**[1]
1	$961
2-Owner	$1,910
2-Staff	$2,146
3-Owner	$2,194
3-Staff	$2,502
4A	$2,941
4B	$3,134
4C	$3,326
4D	$3,567
4E	$3,825
4F	$4,082
4G	$4,386
4H	$4,707
4I	$5,159

The Personal and Incidental (P&I) expenses effective with the January 1, 2009 SSI/SSP payment standard increased from $121.00 to 125.00.

[1] Includes the SSI pass through effective January 1, 2009.

Rate Setting Methodologies

It should be noted that some of the regulatory references below indicate rates may be increased based on periodic reviews showing increased cost. However, these processes are superseded by State statute which currently mandates that all rates are frozen.

Median Rate a/

A median rate is the value of the rate that divides the distribution of all rates into two parts so that an equal number of rates fall above and below that value. For example, if there are three rates, 1, 2, and 3, the median would be 2 as one rate is above and one rate is below. If there is an even number of rates, the median would be the average of the two middle rates. Each regional center calculated, certified, and submitted its median rates to the Department of Developmental Services (DDS). These calculations became the basis for DDS to calculate the statewide median rates.

Usual and Customary Rate a/

Rates set based on the provider's "usual and customary rate" are not subject to the median rate. However, the rate must meet the regulatory definition for a "usual and customary rate." Pursuant to Title 17, Section 57210, sub d. (a)(19), the "usual and customary rate" means the rate which is charged by a provider for a service that is used by both regional center consumers and/or families and where at least 30% of the recipients of the given service are not regional center consumers or their families.

Cost Statement Based Rate b/

New service providers receive a temporary payment rate (TPR). This TPR is the mean rate for like service providers receiving a permanent payment rate. Within 18 months of the start date of the service, the provider must submit 12 consecutive months of actual allowable cost information to DDS for conversion to a permanent payment rate. Once the provider has been notified of the rate established by DDS, the provider and regional center may negotiate a lower level of payment or a service contract. (Title 17, Sections 57210(a)(17), 57520, 57522, 58000(a)(7), 58120, 58122)

Each provider's rate is established utilizing actual allowable cost information and consumer attendance data submitted by the provider. If the calculated rate is within the allowable range of rates for like services, the provider will receive the calculated rate. If, however, the provider's rate is below the lower limit or above the upper limit, the rate will be adjusted up to the lower limit or reduced to the upper limit, as appropriate. Once the provider has been notified of the rate established by DDS, the vendor and regional center may negotiate a lower level of payment or a service contract. (Title 17, Sections 57300(d), 58140, 57540)

Individual Respite Worker Rate

DDS sets rates for In-Home Respite Workers, Vouchered Respite Workers and employees providing respite services through respite facilities. The rate per hour is based on the current California minimum wage, plus a standard fringe benefit and employment cost, such as Workers Compensation Insurance. Effective January 1, 2008, the level of payment shall not exceed $10.71 per consumer per hour, including fringe benefits. (Title 17, Section 57332)

Supported Employment c/

Supported employment rates are established in the California Welfare and Institutions Code Section 4860 (a) (1) which states the hourly rate for supported employment services provided to consumers receiving individualized services shall be thirty dollars and eighty-two cents ($30.82)..... and (b) The hourly rate for group services shall be thirty dollars and eighty-two cents ($30.82), regardless of the number of consumers served in the group.

Alternative Residential Rate Model (ARM)

A methodology for determining rates for the various ARM service levels for residential facilities is contained in Title 17, Sections 56910-56915. The methodology takes into account a number of factors including: 1) calculating the cost of basic living needs for each resident (e.g. housing, utilities, food, furniture, etc.); 2) calculating the indirect, overhead and administrative costs; and 3) calculating the cost to provide direct supervision and special services. Costs in this area include wages and fringe benefits for direct care staff as well as any consultant expense. (Title 17, Sections 56910-56915)

a/ Median Rates FAQs
b/ Reimbursement rates FAQs http://www.dds.ca.gov/Rates/Rates_FAQ.cfm#6
c/ Welfare and Institutions Code Section 4860 (a) (1) and (b)

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REIMBURSEMENT METHODOLOGY FOR HABILITATION SERVICES

Habilitation services are Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation services may be provided to family members if they are for the benefit of the HCBS recipient. Habilitation services include:

- Home-based habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.

- Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which may take place in a residential or non-residential setting

- Supported employment: Supported employment services are defined in California Welfare and Institutions Code § 4851(n), (r), and (s). These services are received by eligible adults who are employed in integrated settings in the community. These individuals are unable to maintain this employment without an appropriate level of ongoing employment support services.

- Pre-vocational services: These services are work activity programs as defined in California Welfare and Institutions Code §4851(e). These services are usually provided in a segregated setting and provide a sufficient amount and variety of work to prepare and maintain eligible adult individuals at their highest level of vocational functioning.

- Behavioral Intervention Services: Behavior intervention services include use of behavior intervention programs; development of programs to improve the recipient's development; behavior tracking and analysis; and the fading of any intrusive intervention measures. The intervention programs will be restricted to generally accepted positive approaches.

- Mobility Habilitation Training: This service is designed to teach individuals how to use public transportation or other modes of transportation which enable them to move about the community independently.

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Description of rate setting methods and standards for each optional Habilitation Service:

- **Foster Family Agency/Certified Family Homes**

Rates are established by the State using its Alternative Residential Rate Model (ARM) for the associated level of service. As required by State statute, the Department maintains a schedule of reimbursement rates for each service level. The effective date of the current ARM rate schedule is January 1, 2009. The schedule is located at www.dds.ca.gov/Rates/ReimbRates.cfm .

- **Foster Family Homes**

Rates are established by the State using its Alternative Residential Rate Model (ARM) for the associated level of service. As required by State statute, the Department maintains a schedule of reimbursement rates for each service level. The effective date of the current ARM rate schedule is January 1, 2009. The schedule is located at www.dds.ca.gov/Rates/ReimbRates.cfm .

- **Small Family Homes**

Rates are established by the State using its Alternative Residential Rate Model (ARM) for the associated level of service. As required by State statute, the Department maintains a schedule of reimbursement rates for each service level. The effective date of the current ARM rate schedule is January 1, 2009. The schedule is located at www.dds.ca.gov/Rates/ReimbRates.cfm .

- **Group Homes**

Rates are established by the State using its Alternative Residential Rate Model (ARM) for the associated level of service. As required by State statute, the Department maintains a schedule of reimbursement rates for each service level. The effective date of the current ARM rate schedule is January 1, 2009. The schedule is located at www.dds.ca.gov/Rates/ReimbRates.cfm .

- **Residential Facilities for Adults or Residential Facility for the Elderly**

Rates are established by the State using its Alternative Residential Rate Model (ARM) for the associated level of service. As required by State statute, the Department maintains a schedule of reimbursement rates for each service level. The effective date of the current ARM rate schedule is January 1, 2009. The schedule is located at www.dds.ca.gov/Rates/ReimbRates.cfm .

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- **Family Home Agency/Adult Family Home**

Rates are established by the State using its Alternative Residential Rate Model (ARM) for the associated level of service. As required by State statute, the Department maintains a schedule of reimbursement rates for each service level. The effective date of the current ARM rate schedule is January 1, 2009. The schedule is located at www.dds.ca.gov/Rates/ReimbRates.cfm .

- **Residential Services – Out-of-State**

Established rate based on services and supports provided. State statute authorizes the Department's Director to purchase out-of –state residential services when there is no available facility within the state.

- **Specialized Residential Facilities (DSS Licensed)**

Effective July 1, 2008, rates for new providers may not exceed the regional center's median rate or the statewide median rate for some provider types, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Supplemental Residential Program Services**

Effective July 1, 2008, rates for new providers may not exceed the regional center's median rate or the statewide median rate for some provider types, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Supported Living Services**

Effective July 1, 2008, rates for new providers may not exceed the regional center's median rate or the statewide median rate for some provider types, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Mobility Training Services Agency**

Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Mobility Training Services Specialist**

Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Adaptive Skills Trainer**

Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Socialization Training Program**

Effective July 1, 2008, rates for new providers may not exceed the regional center's median rate or the statewide median rate for some provider types, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Community Integration Training Program: Agency**

Effective July 1, 2008, rates for new providers may not exceed the regional center's median rate or the statewide median rate for some provider types, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Community Activities Support Services: Individual**

Effective July 1, 2008, rates for new providers may not exceed the regional center's median rate or the statewide median rate for some provider types, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Activity Center**

Rates set by the State pursuant to a cost statement methodology in statute and regulation.

- **Adult Development Centers**

Rates set by the State pursuant to a cost statement methodology in statute and regulation.

- **Behavior Management Program**

Rates set by the State pursuant to a cost statement methodology in statute and regulation.

- **Independent Living Program**

Rates set by the State pursuant to a cost statement methodology in statute and regulation.

- **Independent Living Specialist**

Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

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- **Individual (Day Habilitation-Supplemental Day Services Program Support)**

Effective July 1, 2008, rates for new providers may not exceed the regional center's median rate or the statewide median rate for some provider types, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Agency (Creative Art Program)**

Effective July 1, 2008, rates for new providers may not exceed the regional center's median rate or the statewide median rate for some provider types, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Developmental Specialist**

Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Community Rehabilitation Program (Supported Employment)**

Rates set by statute, Welfare and Institutions Code 4860(a)(1).

- **Community Rehabilitation Program (Pre-Vocational Services, Work Activity Program)**

Rates set by the State pursuant to a cost statement methodology in statute and regulation.

- **In-Home Day Program**

Effective July 1, 2008, rates for new providers may not exceed the regional center's median rate or the statewide median rate for some provider types, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Crisis Team – Evaluation and Behavioral Intervention**

Effective July 1, 2008, rates for new providers may not exceed the regional center's median rate or the statewide median rate for some provider types, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Client/Parent Support Behavior Intervention Training**

Effective July 1, 2008, rates for new providers may not exceed the regional center's median rate or the statewide median rate for some provider types, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Crisis Intervention Facility**

Effective July 1, 2008, rates for new providers may not exceed the regional center's median rate or the statewide median rate for some provider types, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Behavior Analyst**

Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Associate Behavior Analyst**

Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Behavior Management Assistant**

Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Behavior Management Consultant**

Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **HCBS Personal Emergency Response Systems**

Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

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REIMBURSEMENT METHODOLOGY FOR RESPITE CARE

Respite care includes intermittent or regularly scheduled temporary non-medical care (with the exception of colostomy, ileostomy, catheter maintenance, and gastrostomy) and supervision provided in the recipient's own home or in an approved out-of-home location to do all of the following:

1. Assist family members in maintaining the recipient at home;
2. Provide appropriate care and supervision to protect the recipient's safety in the absence of family members;
3. Relieve family members from the constantly demanding responsibility of caring for a recipient; and
4. Attend to the recipient's basic self-help needs and other activities of daily living, including interaction, socialization, and continuation of usual daily routines which would ordinarily be performed by family members.

Respite care can also include Voucher Respite Care. A regional center may offer vouchers to family members to allow the families to procure their own respite services. A family member is defined in State regulations (Title 17 Section 54302) as an individual who:

- Resides with a person with developmental disabilities;
- Is responsible for the 24-hour care and supervision of a person with developmental disabilities; and
- Is not a licensed or certified residential care facility or foster family home receiving funds from any public agency or regional center for the care and supervision provided.

Description of rate setting methods and standards for each optional Respite Care Service:

- **Respite-Individual**

Rates set by regulation, In-Home Respite Worker, Title 17, Section 57332(c)(3).

- **Respite-Service Agency**

Rates set by the State pursuant to a cost statement methodology in statute and regulation.

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- **Adult Day Care Facility**

Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Child Day Care Facility**

Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Respite Facility; Residential Facility**

Rates set based upon the State's Alternative Residential Rate Model or the median rate methodology. Median rates are established by the State.

- **Vouchered Respite Care**

Rates set by regulation.

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REIMBURSEMENT METHODOLOGY FOR PERSONAL CARE SERVICES

Personal Care Services may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/herself. Such assistance most often relates to performance of ADLs and IADLs. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services.

Description of rate setting methods and standards for each optional Personal Care Service:

- **Personal Assistance**

  Effective July 1, 2008, rates for new providers may not exceed the regional center's median rate or the statewide median rate for some provider types, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **HCBS Assistive Technology – Vehicle Modification and Adaptation**

  Usual and customary rates (i.e., the rates which are charged to the general public).

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REIMBURSEMENT METHODOLOGY FOR HOMEMAKER SERVICES

Homemaker services consist of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

Description of rate setting methods and standards for each optional Homemaker Service:

- **Basic Homemaker – Individual**

Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

- **Basic Homemaker – Agency**

Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower. Median rate methodology is mandated in statute; median rates are established by the State.

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STATE/TERRITORY: CALIFORNIA

REIMBURSEMENT METHODOLOGY FOR HOME HEALTH AIDE SERVICES

Home Health Aide services, as ordered by a physician and defined in 42 CFR § 409.45, may include but not be limited to personal care services, simple dressing changes, assistance with medications, assistance with activities that are directly supportive of skilled therapy services that do not require the skills of a therapist to be safely and effectively performed.

Description of rate setting methods and standards for each optional Home Health Aide Services:

- **Home Health Agency**
  Rates are set according to the Schedule of Maximum Allowances (SMA) -- the schedule of the maximum allowable rate for the service provided as established by the Department of Health Care Services for services reimbursable under the Medi-Cal program.

- **Home Health Aide**
  Rates are set according to the Schedule of Maximum Allowances (SMA) -- the schedule of the maximum allowable rate for the service provided as established by the Department of Health Care Services for services reimbursable under the Medi-Cal program.

State Plan Under Title XIX of the Social Security Act
STATE/TERRITORY: CALIFORNIA

REIMBURSEMENT METHODOLOGY FOR ADULT DAY HEALTH CARE SERVICES

Adult Day Health Care Services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. 1915(i) Adult Day Health Care services will be a continuation of services beyond the amount, duration and scope of State Plan benefit.

Description of rate setting methods and standards for Adult Day Health Care Services:

- **Adult Day Health Care**

  Rates are set according to the Schedule of Maximum Allowances (SMA) -- the schedule of the maximum allowable rate for the service provided as established by the Department of Health Care Services for services reimbursable under the Medi-Cal program.

State Plan Under Title XIX of the Social Security Act
STATE/TERRITORY: CALIFORNIA

1915(i) HCBS State Plan Services

Administration and Operation

1. **Program Title** (*optional*): California 1915(i) HCBS State Plan Services

2. **State-wideness.** *(Select one)*:

◉	The State implements this supplemental benefit package statewide, per §1902(a)(1) of the Act.
○	The State implements this benefit without regard to the statewideness requirements in §1902(a)(1) of the Act. *(Check each that applies):*
	☐ Geographic Limitation. HCBS state plan services will only be available to individuals who reside in the following geographic areas or political subdivisions of the State. *(Specify the areas to which this option applies)*:
	☐ Limited Implementation of Participant-Direction. HCBS state plan services will be implemented without regard to state-wideness requirements to allow for the limited implementation of participant-direction. Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals 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 option)*:

3 **State Medicaid Agency (SMA) Line of Authority for Operating the HCBS State Plan Supplemental Benefit Package.** *(Select one)*:

○	The HCBS state plan supplemental benefit package is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:	
	○ The Medical Assistance Unit *(name of unit)*:	
	○ Another division/unit within the SMA that is separate from the Medical Assistance Unit *(name of division/unit)*	
◉	The HCBS state plan supplemental benefit package is operated by *(name of agency)*	
	The Department of Developmental Services (DDS)	
	a separate agency of the State that is not a division/unit of the Medicaid agency. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

4. Distribution of State Plan HCBS Operational and Administrative Functions.

☑ The State assures that in accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration or supervision of the state plan. When a function is performed by other than the Medicaid agency, the entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities.

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Disseminate information concerning the state plan HCBS to potential enrollees	☑	☑	☑	☐
2 Assist individuals in state plan HCBS enrollment	☑	☐	☑	☐
3 Manage state plan HCBS enrollment against approved limits, if any	☐	☐	☐	☐
4 Review participant service plans to ensure that state plan HCBS requirements are met	☑	☑	☑	☐
5 Recommend the prior authorization of state plan HCBS	☐	☐	☑	☐
6 Conduct utilization management functions	☑	☑	☑	☐
7 Recruit providers	☐	☐	☑	☐
8 Execute the Medicaid provider agreement	☐	☐	☑	☐
9 Conduct training and technical assistance concerning state plan HCBS requirements	☑	☑	☑	☐
10 Conduct quality monitoring of individual health and welfare and State plan HCBS program performance.	☑	☑	☑	☐

(Specify, as numbered above, the agencies/entities(other than the SMA) that perform each function):

The "Other State Operating Agency" for all indicated areas above is the Department of Developmental Services (DDS). The "Contracted Entity" functions indicated above will be provided through a contract with DDS, by 21 private, non-profit corporations known as regional centers. Regional centers provide fixed points of contact in the community and coordinate and/or provide community-based services to eligible individuals.

5. ☑ **Conflict of Interest Standards.** The State assures it has written conflict of interest standards that, at a minimum, address the conduct of individual assessments and eligibility determinations.

6. ☑ **Appeals**. The State allows for appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in HCBS state plan services.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.** *(Specify):*

Annual Period	From	To	Projected Number of Participants
Year 1	10/1/2009	9/30/2010	40,000
Year 2	10/1/2010	9/30/2111	42,000
Year 3	10/1/2111	9/30/2012	44,000
Year 4	10/1/2112	9/30/2113	46,000
Year 5	10/1/2113	9/30/2114	48,000

2. **Optional Annual Limit on Number Served.** *(Select one):*

◉	The State does not limit the number of individuals served during the Year.
○	The State chooses to limit the number of individuals served during the Year. *(Specify):*

Annual Period	From	To	Annual Maximum Number of Participants
Year 1			
Year 2			
Year 3			
Year 4			
Year 5			

☐	The State chooses to further schedule limits within the above annual period(s). *(Specify):*

3. **Waiting List.** *(Select one):*

◉	The State will not maintain a waiting list.
○	The State will maintain a single list for entrance to the HCBS state plan supplemental benefit package. State-established selection policies: are based on objective criteria; meet requirements of the Americans with Disabilities Act and all Medicaid regulations; ensure that otherwise eligible individuals have comparable access to all services offered in the package.

Financial Eligibility

1. ☑ **Income Limits.** The State assures that individuals receiving state plan HCBS are in an eligibility group covered under the State's Medicaid state plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL).

2. **Medically Needy.** *(Select one)*

◉	The State does not provide HCBS state plan services to the medically needy.
○	The State provides HCBS state plan services to the medically needy *(select one):*
○	The State elects to waive the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
○	The State does not elect to waive the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Independent evaluations/reevaluations to determine whether applicants are eligible for HCBS are performed (*select one*):

○	Directly by the Medicaid agency
◉	By Other (*specify*):
	Regional centers

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** There are qualifications (that are reasonably related to performing evaluations) for persons responsible for evaluation/reevaluation for eligibility. *(Specify qualifications):*

The minimum requirement for conducting evaluations/reevaluations is a degree in social sciences or a related field. Case management experience in the developmental disabilities field or a related field may be substituted for education on a year-for-year basis.

3. ☑ **Independence of Evaluators and Assessors.** The State assures that evaluators of eligibility for HCBS state plan services and assessors of the need for services are independent. They are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - service providers, or individuals or corporations with financial relationships with any service provider.

4. **Needs-based HCBS Eligibility Criteria.** Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for HCBS state plan services. The criteria take into account the individual's support needs and capabilities and may take into account the individual's ability to perform two or more ADLs, the need for assistance, and other risk factors: *(Specify the needs-based criteria):*

For the period from October 1, 2009 to September 30, 2010, the individual has a need for assistance demonstrated by:

A need for habilitation services, as defined in Section 1915(c)(5) of the Social Security Act (42 U.S.C. § 1396 *et seq.*), to teach or train in new skills that have not previously been acquired, such as skills enabling the individual to respond to life changes and environmental demands (as opposed to rehabilitation services to restore functional skills); and

A likelihood of retaining new skills acquired through habilitation over time; and

A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential, that continues, or can be expected to continue, indefinitely; and

The existence of significant functional limitations in at least three of the following areas of major life activity, as appropriate to the person's age:

Receptive and expressive language;

Learning;

Self-care;

Mobility;

Self-direction;

Capacity for independent living.

Commencing October 1, 2010, in addition to the needs identified above, the individual must also have a diagnosis of a developmental disability, as defined in Section 4512 of the Welfare and Institutions Code and Title 17, California Code of Regulations, §54000 and §54001. Further, "economic self-sufficiency" will also be considered an area of major life activity for the purpose of identifying significant functional limitations.

5. ☑ **Needs-based Institutional and Waiver Criteria.** There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of HCBS state plan services. Individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Include copies of the State's official documentation of the need-based criteria for each of the following):*

- *Applicable Hospital*
- *NF*
- *ICF/MR*
-

Differences Between Level of Care Criteria

State Plan HCBS Needs-based eligibility criteria	NF	ICF/MR LOC	Hospitalization LOC
The individual meets the following criteria: • A need for habilitation services, as defined in Section 1915(c)(5) of the Social Security Act (42 U.S.C. § 1396 *et seq.*), to teach or train in new skills that have not previously been acquired, such as skills enabling the individual to respond to life changes and environmental demands (as opposed to	Skilled nursing procedures provided as a part of skilled nursing care are those procedures which must be furnished under the direction of a registered nurse in response to the attending physician's order. The need must be for a level of service which includes the continuous availability of procedures such as,	The individual must be diagnosed with a developmental disability and a qualifying developmental deficit exists in either the self-help or social-emotional area. For self-help, a qualifying developmental deficit is represented by two moderate or severe skill task impairments in eating, toileting, bladder control or dressing skill. For the social-emotional area, a qualifying developmental deficit is	The individual requires: • Continuous availability of facilities, services, equipment and medical and nursing personnel for prevention, diagnosis or treatment of acute illness or injury.

State Plan HCBS Needs-based eligibility criteria	NF	ICF/MR LOC	Hospitalization LOC
rehabilitation services to restore functional skills); and • A likelihood of retaining new skills acquired through habilitation over time; and • A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential, that continues, or can be expected to continue, indefinitely; and • The existence of significant functional limitations in at least three of the following areas of major life activity, as appropriate to the person's age • Receptive and expressive language; • Learning; • Self-care; • Mobility; • Self-direction;	but not limited to, the following: • Nursing assessment of the individuals' condition and skilled intervention when indicated; • Administration of injections and intravenous of subcutaneous infusions; • Gastric tube or gastronomy feedings; • Nasopharygeal aspiration; • Insertion or replacement of catheters • Application of dressings involving prescribed medications; • Treatment of extensive decubiti; • Administration of medical gases	represented by two moderate or severe impairments from a combination of the following; social behavior, aggression, self-injurious behavior, smearing, destruction of property, running or wandering away, or emotional outbursts.	

State Plan HCBS Needs-based eligibility criteria	NF	ICF/MR LOC	Hospitalization LOC
• Capacity for independent living; • Commencing October 1, 2010, in addition to the needs identified above, the individual must also have a diagnosis of a developmental disability, as defined in Section 4512 of the Welfare and Institutions Code and Title 17, California Code of Regulations, §54000 and §54001. Further, "economic self-sufficiency" will also be considered an area of major life activity for the purpose of identifying significant functional limitations.			

6. ☑ **Reevaluation Schedule**. The State assures that needs-based reevaluations are conducted at least annually.

7. ☑ **Adjustment Authority**. The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

8. Residence in home or community. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not an institution. *(Specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS, if applicable. Describe the criteria by which the State determines that these settings are not institutional in character such as privacy and unscheduled access to food, activities, visitors, and community pursuits outside the facility):*

Residential settings can include facilities that may house four or more individuals that are unrelated to the service provider. In these instances, the person-centered planning team must determine that the setting is appropriate to the individual's need for independence, choice and community integration. The determination will take into consideration the provision of the following:

1. Bedrooms which are shared by no more than two individuals, with one person in a bedroom being preferred.

2. Common living areas that are conducive for interaction between residents, and residents and their guests.

3. Residents have the opportunity to make decisions on their day-to-day activities, including visitors and when and what to eat, in their home and in the community.

4. Services which meet the needs of each resident.

5. Residents have the privacy necessary for personal hygiene, dressing, and being by themselves, when they choose.

Residential settings that contain multiple independent living units (e.g. apartments) are considered home-like settings for the purposes of this state plan amendment.

Intermediate Care Facilities are not included as residential settings under this State Plan Amendment.

Person-Centered Planning & Service Delivery

1. ☑ The State assures that there is an independent assessment of individuals determined to be eligible for HCBS. The assessment is based on:
   - An objective face-to-face evaluation by a trained independent agent;
   - Consultation with the individual and others as appropriate;
   - An examination of the individual's relevant history, medical records, care and support needs, and preferences;
   - Objective evaluation of the inability to perform, or need for significant assistance to perform 2 or more ADLs (as defined in § 7702B(c)(2)(B) of the Internal Revenue Code of 1986); and
   - Where applicable, an evaluation of the support needs of the individual (or the individual's representative) to participant-direct.
2. ☑ The State assures that, based on the independent assessment, the individualized plan of care:
   - Is developed by a person-centered process in consultation with the individual, the individual's treating physician, health care or supporting professional, or other appropriate individuals, as defined by the State, and where appropriate the individual's family, caregiver, or representative;
   - Identifies the necessary HCBS to be furnished to the individual, (or, funded for the individual, if the individual elects to participant-direct the purchase of such services);
   - Takes into account the extent of, and need for, any family or other supports for the individual;
   - Prevents the provision of unnecessary or inappropriate care;
   - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
   - Is reviewed at least annually and as needed when there is significant change in the individual's circumstances.
3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

   The minimum requirement is a degree in social sciences or a related field. Case management experience in the developmental disabilities field or a related field may be substituted for education on a year-for-year basis.

4. **Responsibility for Service Plan Development**. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

   The minimum requirement is a degree in social sciences or a related field. Case management experience in the developmental disabilities field or a related field may be substituted for education on a year-for-year basis.

5. **Supporting the Participant in Service Plan Development**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

   a) *the supports and information made available* – The service plan, commonly referred to as the individual program plan (IPP), is developed through a process of individualized needs determination, which includes gathering information from providers of services and supports, and

is prepared jointly by the planning team. Each individual is paired with a case manager to assist in the IPP development. Information available for supporting recipients in the IPP process includes but is not limited to the following documents, all of which are available using the links below or through the DDS website at www.dds.ca.gov:

1. "Individual Program Plan Resource Manual" - This resource manual is designed to facilitate the adoption of the values that lead to person-centered individual program planning. It is intended for use by all those who participate in person-centered planning. It was developed with extensive input from service recipients, families, advocates and providers of service and support.

2. "Person Centered Planning" - This publication consists of excerpts taken from the Individual Program Plan Resource Manual to provide recipients and their families information regarding person-centered planning.

3. "From Conversations to Actions Using the IPP" - This booklet shares the real life stories of how recipients can set their goals and objectives and work through the IPP process to achieve them.

4. "From Process to Action: Making Person-Centered Planning Work" - This guide provides a quick look at questions that can help a planning team move the individual program plan from process to action focusing on the person and the person's dreams for a preferred future.

b) *The participant's authority to determine who is included in the process* - The IPP planning team, at a minimum, consists of the recipient and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, and an authorized regional center representative. With the consent of the recipient/conservator, other individuals, may receive notice of the meeting and participate.

6. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the service plan):*

The case manager informs the recipient and/or his or her legal representative of qualified providers of services determined necessary through the IPP planning process. Recipients may meet with qualified providers prior to the final decision regarding providers to be identified in the service plan.

7. **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):*

On a biennial basis, DHCS in conjunction with DDS will review a representative sample of recipient IPPs to ensure all service plan requirements have been met.

8. **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 §74.53. Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency	☐	Operating agency	☐	Case manager
☑	Other (*specify):*	Regional centers are required to maintain service plans for a minimum of five years.			

Services

1. **HCBS State Plan Services.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title from the options for HCBS State plan services in Attachment 4.19-B):*	
Service Title:	**Habilitation**
Service Definition (Scope):	

Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation services may be provided to family members if they are for the benefit of the HCBS recipient. Habilitation services include:

- Home-based habilitation including habilitation in residential settings: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments will not be made for the routine care and supervision which would be expected to be provided by a family, or for activities or supervision for which a payment is made by a source other than Medi-Cal. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents.

- Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which may take place in a residential or non-residential setting. Services shall normally be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

    - Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation service may serve to reinforce skills or lessons taught in school, therapy, or other settings.

- Supported employment: Supported employment services are defined in California Welfare and Institutions Code § 4851(n), (r), and (s). These services are received by eligible adults who are employed in integrated settings in the community. These individuals are unable to maintain this employment without an appropriate level of ongoing employment support services.

    - The supported employment services provided under 1915(i) are:

        - Group Supported Employment (defined in California Welfare and Institutions Code §4851(r).

            - Training and supervision of an individual while engaged in work in an integrated

setting in the community.

- Recipients in group-supported employment receive supervision 100% of the time by the program and usually are paid according to productive capacity. A particular individual may be compensated at a minimum wage or at a rate less than minimum wage.

▪ Individual Supported Employment (defined in California Welfare and Institutions Code §4851(s).

- Training and supervision in addition to the training and supervision the employer normally provides to employees.
- Support services to ensure job adjustment and retention, provided on an individual basis in the community, as defined in California Welfare and Institutions Code §4851(q):
  - Job development
  - Job analysis
  - Training in adaptive functional skills
  - Social skill training
  - Ongoing support services (e.g., independent travel, money management)
  - Family counseling necessary to support the individual's employment
  - Advocacy related to the employment, such as assisting individuals in understanding their benefits
  - Employer intervention
- Recipients receiving individual services normally earn minimum wage or above and are on the employer's payroll. Individuals receiving these services usually receive supervision 5-20% of the time by the program. The remainder of the time, the employer provides all supervision and training.

o The above described services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 (29 USC Section 730) or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 USC 1401(16 and 17).

- Pre-vocational services: These services are work activity programs as defined in California Welfare and Institutions Code §4851(e). These services are usually provided in a segregated setting and provide a sufficient amount and variety of work to prepare and maintain eligible adult individuals at their highest level of vocational functioning. Individuals receive compensation based upon their productive capacity and upon prevailing wage. Accordingly, the rate of compensation for any individual varies, and may exceed 50% of minimum wage, because of variations in the prevailing wage rate for particular tasks and the individual's productivity in performing the task. Services are limited to:

  o Work services consisting of remunerative employment which occur no less than 50% of the client's time in program, as defined in Title 17, California Code of Regulations, Section 58820(c)(1).

  o Work adjustment services, as defined in Title 17, California Code of Regulations, Section 58820(c)(2)(A)(1-9), consisting of:

    ▪ Physical capacities development
    ▪ Psychomotor skills development

- Interpersonal and communicative skills
- Work habits development
- Development of vocationally appropriate dress and grooming
- Productive skills development
- Work practices training
- Work-related skills development
- Orientation and preparation for referral to Vocational Rehabilitation.

o Supportive habilitation services as defined in Title 17, California Code of Regulations, §58820(c)(2)(B)(1-5):

- Personal safety practices training
- Housekeeping maintenance skills development
- Health and hygiene maintenance skills development
- Self-advocacy training, individual counseling, peer vocational counseling, career counseling and peer club participation
- Other regional center approved vocationally related activities

o No more than 50% of the individual's time in program can be spent in a combination of work adjustment and supportive habilitation services.

o The above-described services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 (29 USC Section 730) or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17)).

- Behavioral Intervention Services: Behavior intervention services include use of behavior intervention programs; development of programs to improve the recipient's development; behavior tracking and analysis; and the fading of any intrusive intervention measures. The intervention programs will be restricted to generally accepted positive approaches.

- Mobility Habilitation Training: This service is designed to teach individuals how to use public transportation or other modes of transportation which enable them to move about the community independently.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies)*:	
☐	Categorically needy *(specify limits)*:
☐	Medically needy *(specify limits)*:

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

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:

Foster Family Agency (FFA)-Certified Family Homes	FFA licensed pursuant to Health and Safety Code §§1500-1567.8 An appropriate business license as required by the local jurisdiction where the agency is located.	Certified Family Homes; Title 22, CCR, § 88030	Title 17, CCR,§§ 54342(a)(68) and (a)(70); Title 22, CCR §§ 88000-88087.
Foster Family Homes Payment for this service will not be duplicated or supplanted through Medicaid funding.	Health and Safety Code §§1500-1567.8 An appropriate business license as required by the local jurisdiction where the agency is located.		Title 17, CCR, §§ 54342(a)(68) and (a)(70); Title 22, CCR §§89200-89587.1
Small Family Homes	Health and Safety Code §§1500-1567.8 An appropriate business license as required by the local jurisdiction where the agency is located.		Administrator Requirements - Applies to all community care facilities: · Criminal Record Clearance; · Medical assessment including TB clearance; · Knowledge of requirements for providing the type of care and supervision needed by clients, including ability to communicate with clients; · Knowledge of and ability to comply with applicable laws and regulations; · Ability to maintain or supervise the maintenance of financial and other records; · Ability to direct the work of others;

			· Ability to establish the facility's policy, program and budget; · Ability to recruit, employ, train, and evaluate qualified staff, and to terminate employment of staff. Licensee/Administrator Qualifications · Child Abuse Index Clearance; · At least 18 years of age; · Documented education, training, or experience in providing family home care and supervision appropriate to the type of children to be served. The amount of units or supervision appropriate to the type of children to be served. The amount of units or training hours is not specified. The following are examples of acceptable education or training topics. Programs which can be shown to be similar are accepted: · Child Development; · Recognizing and/or dealing with learning disabilities; · Infant care and stimulation; · Parenting skills; · Complexities, demands and special needs of children in placement; · Building self esteem, for the licensee or the children; · First aid and/or CPR; · Record keeping; · Bonding and/or safeguarding of children's property; · Licensee rights and grievance process; · Licensing and placement regulations; · Right and responsibilities of family home providers. Title 17, CCR, §§ 54342(a)(68) and (a)(70); Title 22, CCR §§ 83000-83088.
Group Homes	Health and Safety Code §§ 1500-1567.8 An appropriate business		Title 17, CCR, § 54342(a)(68) and (70); Title 22, CCR, § 84000-84808

	license as required by the local jurisdiction where the agency is located.		
Residential Facilities for Adults or Residential Care Facility for the Elderly	Health and Safety Code §§1500-1569.87 An appropriate business license as required by the local jurisdiction where the agency is located.	N/A	Administrator Requirements - Applies to all community care facilities: • Criminal Record Clearance; • Medical assessment including TB clearance; • Knowledge of requirements for providing the type of care and supervision needed by clients, including ability to communicate with clients; • Knowledge of and ability to comply with applicable laws and regulations; • Ability to maintain or supervise the maintenance of financial and other records; • Ability to direct the work of others; • Ability to establish the facility's policy, program and budget; • Ability to recruit, employ, train, and evaluate qualified staff, and to terminate employment of staff. Administrator Qualifications • At least 21 years of age; • High school graduation or a GED; • Complete a program approved by CCLD that consists of 35 hours of classroom instruction ○ 8 hrs. in laws, including resident's personal rights, regulations, policies, and procedural standards that impact the operations of adult residential facilities; ○ 3 hrs. in business operations; ○ 3 hrs. in management and supervision of staff; ○ 5 hrs. in the psychosocial needs of the facility residents; ○ 3 hrs. in the use of community and support services to meet the resident's needs;

			○ 4 hrs. in the physical needs of the facility residents; ○ 5 hrs. in the use, misuse and interaction of drugs commonly used by facility residents; ○ 4 hrs. on admission, retention, and assessment procedures; • Pass a standardized test, administered by the Department of Social Services with a minimum score of 70%. For a capacity of 7 - 15 clients - • 1 year work experience in residential care. **ARF**: Title 22, CCR, §§85000-85092; **RCFE**: Title 22, CCR, §§87100-87793 Title 17, CCR, § 54342(a)(67 and 69).
Family Home Agency/Adult Family Home(AFH)	No state licensing category. An appropriate business license as required by the local jurisdiction where the agency is located.	AFH Title 17, CCR, §56088	Selection criteria for hiring purposes should include but not be limited to: education in the fields of social work, psychology, education of related areas; experience with persons with developmental disabilities; experience in program management, fiscal management and organizational development. Title 17, CCR, §54342(a)(28); Title 17, CCR, §§56075-56099
Residential Facilities (Out of State)	Appropriate Facility License, as required by State law. An appropriate business license as required by the local jurisdiction where the agency is located.	N/A	Provide an out-of-state residential program for the service recipient. Department approval is required per the Welfare and Institutions Code, Section 4519.

Specialized Residential Facilities (DSS Licensed)	Health and Safety Code §§1500-1567.8; or §1567.50 An appropriate business license as required by the local jurisdiction where the agency is located.	Facilities meeting the requirements in Welfare & Institutions Code, Sections 4684.50 – 4684.73 are certified by DDS pursuant to Health and Safety Code §1567.50	A regional center shall classify a vendor as a DSS Licensed-Specialized Residential Facility provider if the vendor operates a residential care facility licensed by the Department of Social Services (DSS) for individuals who require 24 hour care and supervision and whose needs cannot be appropriately met within the array of other community living options available. Primary services provided by a DSS Licensed-Specialized Residential Facility may include personal care and supervision services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law) and therapeutic social and recreational programming, provided in a home-like environment. Incidental services provided by a DSS Licensed-Specialized Residential Facility may include home health care, physical therapy, occupational therapy, speech therapy, medication administration, intermittent skilled nursing services, and/or transportation, as specified in the IPP. This vendor type provides 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and the provision of supervision and direct care support to ensure the recipients' health, safety and well-being. Other individuals or agencies may also furnish care directly, or under arrangement with the DSS Licensed-Specialized Residential Facility, but the care provided by these other entities must supplement the care provided by the DSS Licensed-Specialized Residential Facility and does not supplant it.
Residential Facilities (Supplemental Program Support)	Health and Safety Code §§ 1500-1567.8	N/A	Entities who employ, train, and assign personnel to provide program support services (in excess of the amount required by regulations) in a residential

	An appropriate business license as required by the local jurisdiction where the agency is located.		setting shall have staff who meet the following minimum requirements: a. The ability to perform the functions required in the individual plan of care; b. Demonstrated dependability and personal integrity; and c. Willingness to pursue training as necessary, based upon the individual's needs.
Supported Living Services	No state licensing category. An appropriate business license as required by the local jurisdiction where the agency is located.	N/A	Requires service design, staff appropriate to services rendered with skills to establish and maintain constructive and appropriate personal relationship with recipients, minimize risks of endangerment to health, safety, and well-being of recipients, perform CPR and operate 24-hour emergency response systems, achieve the intended results of services being performed and maintain current and valid licensure, certification, or registration as are legally required for the service. Also requires staff orientation and training in theory and practice of supported living services and recipient training in supported living services philosophy, recipient rights, abuse prevention and reporting, grievance procedures and strategies for building and maintaining a circle of support. Title 17, CCR, §§54349; 58600-58680.
Mobility Training Services Agency	No state licensing category. An appropriate business license as required by the local jurisdiction where the agency is located.		Agencies who employ, train, and assign personnel to teach individuals how to use public transportation or other modes of transportation which will enable them to move about the community independently, shall possess the following minimum requirements: 1. Appropriate business license as required by local jurisdiction; and 2. Personnel who possess the skill, training or education necessary to teach individuals how to use public transportation or other modes of transportation which enable them to move about the community independently including:

			a) previous experience working with individuals with developmental disabilities and awareness of associated problems, attitudes and behavior patterns; b) a valid California Driver's license and current insurance; c) ability to work independently with minimal supervision according to specific guidelines; and d) flexibility and adaptive skills to facilitate individual recipient needs. Title 17, CCR, § 54342(a)(47).
Mobility Training Services Specialist	No state licensing category. An appropriate business license as required by the local jurisdiction where the agency is located.	N/A	Individuals who teach individuals how to use public transportation or other modes of transportation which enable them to move about the community independently, shall possess the following minimum requirements: 1. Previous experience working with individuals with developmental disabilities and awareness of associated problems, attitudes and behavior patterns; 2. A valid California Driver's license and current insurance; 3. Ability to work independently, flexibility and adaptive skills to facilitate individual recipient needs. Title 17, CCR, §54342(a)(48).
Adaptive Skills Trainer	No state licensing category. An appropriate business license as required by the local jurisdiction where the agency is located.	N/A	Master's degree in education, psychology, counseling, nursing, social work, applied behavior analysis, behavioral medicine, speech and language or rehabilitation; and at least one year of experience in the designing and implementation of adaptive skills training plans. Title 17, CCR, §54342(a)(3).
Socialization Training Program: Agency; Community Integration Training Program:	No state licensing category.	N/A	Qualifications and training of staff per agency guidelines. 1. Socialization Training Program:

Agency; Community Activities Support Services.	An appropriate business license as required by the local jurisdiction where the agency is located.		Program provides socialization opportunities for school age individuals. 2. Community Integration Training Program: Program designed to provide training and skill development in conflict resolution, community participation including knowledge of, and access to community resources, interpersonal relationships, and personal habits necessary to obtain and retain employment. Program directors must have at least a bachelor's degree. Direct service workers may be qualified by experience. 3. Community Activities Support Services: Provides support on a time-limited basis to accomplish various activities for recipients.
Activity Center	Facility license (Health and Safety Code §§ 1500-1567.8) An appropriate business license as required by the local jurisdiction where the agency is located.	N/A	Requires written program design, recipient entrance and exit criteria, staff training, etc. Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills. Staff to recipient ratio = 1:8. Title17 CCR 54342(a)(1) Title 17 CCR, sections 56710-56756
Adult Development Centers	Facility license (Health and Safety Code §§ 1500-1567.8)	N/A	Requires written program design, recipient entrance and exit criteria, staff training, etc. Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three

	An appropriate business license as required by the local jurisdiction where the agency is located.		years experience plus demonstrated supervisory skills. Staff to recipient ratio = 1:4. Staffing ratio not to exceed 1:8 for program component serving seniors. Title17 CCR 54342(a)(6) Title 17 CCR, sections 56710-56756
Behavior Management Program	Facility license (Health and Safety Code §§ 1500-1567.8) An appropriate business license as required by the local jurisdiction where the agency is located.	N/A	Requires written program design, recipient entrance and exit criteria, staff training, etc. Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills. Staff to recipient ratio = 1:3. Staffing ratio not to exceed 1:8 for program component serving seniors. Title 17 CCR 54342 (a)(14), Title 17 CCR sections 56710-56756
Independent Living Program	No state licensing category. An appropriate business license as required by the local jurisdiction where the agency is located.	N/A	Requires written program design, recipient entrance and exit criteria, staff training, etc. Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills. Staff to recipient ratio = up to 1:3. Staffing ratio not to exceed 1:8 for program component serving seniors. Title 17 CCR 54342 (a)(35), Title 17 CCR sections 56710-56756
Independent Living Specialist	No state licensing category. An appropriate	N/A	Possesses the skill, training, or education necessary to teach recipients to live independently and/or to provide the supports necessary for the recipient to maintain a self-sustaining, independent living situation in the

	business license as required by the local jurisdiction where the agency is located.		community, such as one year experience providing services to individuals in a residential or non-residential setting and possession of at least a two-year degree in a subject area related to skills training and development of program plans for eligible individuals. Title 17, CCR, §54342(a)(36)
Supplemental Day Services Program Support	No state licensing category. An appropriate business license as required by the local jurisdiction where the agency is located.	N/A	A regional center shall classify a vendor as a Supplemental Day Services Program Support provider if the vendor provides or obtains time-limited, supplemental staffing in excess of the amount required by regulation.
Creative Art Program	No state licensing category. An appropriate business license as required by the local jurisdiction where the agency is located.	N/A	Program may be center-based or be provided in the recipient's residence. Provider qualifications include: Program Director: Equivalent of a high school diploma and experience with persons with developmental disabilities. Direct Care Staff: Must have artistic experience as demonstrated through a resume.
Developmental Specialist	No state licensing category. An appropriate business license as required by the local jurisdiction where the	Certification by an accredited hospital as having successfully completed a one-year developmental specialist training program.	In lieu of certification, the vendor possesses a Master's Degree in Developmental Therapy from an accredited college or university. Title 17, CCR, § 54342(a)(22).

	agency is located.		
Community Rehabilitation Program (Supported Employment)	No state licensing category. Federal/State Tax Exempt Letter. An appropriate business license as required by the local jurisdiction where the agency is located.	Certification by Department of Rehabilitation and/or Commission on Accreditation for Rehabilitation Facilities	Programs must initially meet the Department of Rehabilitation Program certification standards and be accredited by CARF within four years of providing services. Welfare and Institutions Code,§ 4850 - 4867 Title 17, CCR, §§58810-58812; 58830-58834
Community Rehabilitation Program (Pre-Vocational Services, Work Activity Program)	No state licensing category. Federal/State Tax Exempt Letter. An appropriate business license as required by the local jurisdiction where the agency is located.	Certification by Department of Rehabilitation and/or Commission on Accreditation for Rehabilitation Facilities	Programs must initially meet the Department of Rehabilitation Program certification standards and be accredited by CARF within four years of providing services. Welfare and Institutions Code,§ 4850 - 4867 Title 17, CCR, §§58810-58822
In-Home Day Program	No state licensing category. An appropriate business license as required by the local jurisdiction where the	N/A	Providers may include employees of community-based day, pre-vocation, or vocational programs. An in-home day program must have a provision for an annual assessment process to ensure recipient participation in this type of program remains appropriate.

	agency is located.		
Crisis Team-Evaluation and Behavioral Intervention	No state licensing category. An appropriate business license as required by the local jurisdiction where the agency is located.	N/A	The vendor provides crisis intervention services designed to support and stabilize the recipient in the recipient's current living arrangement or other appropriate setting (e.g., day program, school, community respite). This service includes, but is not limited to: consultation with parents, individuals, or providers of services to develop and implement individualized crisis treatment, as well as supplemental crisis intervention services.
Client/Parent Support Behavior Intervention Training	Licensed in accordance with Business and Professions Code as appropriate to the skilled professions of staff. An appropriate business license as required by the local jurisdiction where the agency is located.	Psychologist, Behavior Analyst or, Associate Behavior Analyst (if required): Certification by the national Behavior Analyst Certification Board.	Program utilizes licensed and/or certified personnel as appropriate to provide training to parents or others on the use of behavioral intervention techniques pursuant to the individual's service plan.
Crisis Intervention Facility	Health and Safety Code §§1500-1569.87 An appropriate business license as required by the local	Adult Family Home Title 17, CCR, §56088 Certified Family Homes; Title 22, CCR, § 88030 Service may be provided in any of the facility types identified previously.	Administrator Requirements - Applies to all community care facilities: • Criminal Record Clearance; • Medical assessment including TB clearance; • Knowledge of requirements for providing the type of care and supervision needed by clients, including ability to communicate with clients; • Knowledge of and ability to comply with applicable laws and

	jurisdiction where the agency is located.		regulations; • Ability to maintain or supervise the maintenance of financial and other records; • Ability to direct the work of others; • Ability to establish the facility's policy, program and budget; • Ability to recruit, employ, train, and evaluate qualified staff, and to terminate employment of staff. Administrator Qualifications • At least 21 years of age; • High school graduation or a GED; • Complete a program approved by CCLD that consists of 35 hours of classroom instruction: ° 8 hrs. in laws, including resident's personal rights, regulations, policies, and procedural standards that impact the operations of adult residential facilities; ° 3 hrs. in business operations; ° 3 hrs. in management and supervision of staff; ° 5 hrs. in the psychosocial needs of the facility residents; ° 3 hrs. in the use of community and support services to meet the resident's needs; ° 4 hrs. in the physical needs of the facility residents; ° 5 hrs. in the use, misuse and interaction of drugs commonly used by facility residents; ° 4 hrs. on admission, retention, and assessment procedures; • Pass a standardized test, administered by the Department of Social Services with a minimum score of 70%. For a capacity of 7 - 15 clients - 1 year work experience in residential care.
Behavior Analyst	Licensed in accordance with	Certification by the national Behavior Analyst Certification	Title 17, CCR, § 54342(a)(11)

	Business and Professions Code as appropriate to the skilled professions staff. An appropriate business license as required by the local jurisdiction where the agency is located.	Board.	
Associate Behavior Analyst	No state licensing category. An appropriate business license as required by the local jurisdiction where the agency is located.	Certification by the national Behavior Analyst Certification Board	Works under the direct supervision of a Behavior Analyst or Behavior Management Consultant. Title 17, CCR, § 54342(a)(8)
Behavior Management Assistant	Psychology assistant; Associate Licensed Clinical Social Worker Business and Professions Code §2913; §4996-4996.2 An appropriate business license as	N/A	Bachelor of Arts or Science and either 12 semester units in applied behavior analysis and one year of experience in designing or implementing behavior modification intervention services; or two years experience in designing or implementing behavior modification intervention services. Title 17, CCR, § 54342(a)(12).

	required by the local jurisdiction where the agency is located.		
Behavior Management Consultant	Psychologist, Licensed Clinical Social Worker, Marriage, Family Child Counselor. Business and Professions Code, §2940-2948; §4996-4996.2, §4980-4981 An appropriate business license as required by the local jurisdiction where the agency is located.	N/A	In addition to a license as a clinical social worker, a psychiatric social worker shall have two years post master's experience in a mental health setting. Title 17, CCR, § 54342(a)(13)
Personal Emergency Response Systems	No state licensing category. An appropriate business license as required by the local jurisdiction where the agency is located.	Certification / registration as appropriate for the type of system being purchased.	Providers shall be competent to meet applicable standards of installation, repair, and maintenance of emergency response systems. Providers shall also be authorized by the manufacturer to install, repair, and maintain such systems if such a manufacturer's authorization program exists. Providers of human emergency response services shall possess or have employed persons who possess current licenses, certifications or registrations as necessary and required by the State of California for persons providing personal emergency response services.
Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:			

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
All habilitation providers	Vendored by the regional center in accordance with Title 17, CCR, §§ 54310 and 54326.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Licensed Community Care Facilities	Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers	Annually
Department of Developmental Services (DDS) certified facilities	DDS	Every six months
Family Home Agency/Adult Family Home (AFH)	Family Home Agency –by regional centers and DDS AFH –by the Family Home Agency, regional centers and DDS	Annually for Family Home Agency At least annually
Community Rehabilitation Program (Supported Employment and Pre-Vocational services)	Commission on Accreditation of Rehabilitation Facilities (CARF)	Within four years at start-up; every one to three years thereafter
Personal Emergency Response Systems	Vendored by the regional center in accordance with Title 17, CCR §§ 54310 and 54326.	Upon application for vendorization

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title from the options for HCBS State plan services in Attachment 4.19-B)*:

Service Title: **Respite Care**

Service Definition (Scope):

Intermittent or regularly scheduled temporary non-medical care (with the exception of colostomy, ileostomy, catheter maintenance, and gastrostomy) and supervision provided in the recipient's own home or in an approved out of home location to do all of the following:

1. Assist family members in maintaining the recipient at home;
2. Provide appropriate care and supervision to protect the recipient's safety in the absence of family members;
3. Relieve family members from the constantly demanding responsibility of caring for a recipient; and
4. Attend to the recipient's basic self-help needs and other activities of daily living, including interaction, socialization, and continuation of usual daily routines which would ordinarily be performed by family members.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following locations:

- Individual's home or place of residence
- Family member's home
- Respite care facility licensed by CCLD such as an Adult Residential Facility, Residential Care Facility for the Elderly, Small Family Home, Group Home, or Foster Family Home
- Other community care residential facility approved by the State that is not a private residence, such as:
  - Adult Family Homes
  - Certified Family Homes
  - Adult Day Care Facility
  - Child Day Care Facility
  - Licensed Preschool

Voucher Respite Care: A regional center may offer vouchers to family members to allow the families to procure their own respite services. A family member is defined in State regulations (Title 17 Section 54302) as an individual who:

- Resides with a person with developmental disabilities;
- Is responsible for the 24-hour care and supervision of a person with developmental disabilities; and
- Is not a licensed or certified residential care facility or foster family home receiving funds from any public agency or regional center for the care and supervision provided.

When vouchers are issued they shall be used in lieu of, and shall not exceed the cost of, services the regional center would otherwise provide and be issued only for services which are unavailable from generic agencies. This is an option that may be selected instead of respite provided by staff hired by an authorized agency through the regional center. Voucher respite care may be provided only if approved in the recipient's plan of care (IPP). Services under this option will be administered as follows:

1. The vendored family member will select and train an individual to render respite services. Services may also be obtained from a respite agency, residential or day care facility, or preschool [out-of-home respite], or respite facility.
2. The vendored family member signs an agreement with the regional center acknowledging responsibility for compliance with caregiver qualifications (see below) and Internal Revenue Service laws.
3. The regional center issues the vouchers to the family based on the number of authorized hours of service pursuant to the IPP.

Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☑	Categorically needy *(specify limits):*
	Unless an exemption is granted by the regional center, in-home respite may be provided up to a maximum of 90 hours in a quarter. Additionally, unless an exemption is granted by the regional center, out-of-home respite may be provided up to a maximum of 21 days in a fiscal year.

☐	Medically needy *(specify limits):*

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

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Respite-Individual	No state licensing category. A business license as required by the local jurisdiction where the agency is located.		Has received Cardiopulmonary Resuscitation (CPR) and First Aid training from agencies offering such training, including, but not limited to, the American Red Cross; and has the skill, training, or education necessary to perform the required services. Title 17, CCR, § 54342(a)(40)
Respite-Service Agency	No state licensing category. An appropriate business license as required by the local jurisdiction where the agency is located.		Title 17, CCR, § 54342(a)(39) and §§ 56780-56802
Adult Day Care Facility	Health and Safety Code §§ 1500 - 1567.8 An appropriate business license as required by the local jurisdiction where the agency is located.		The administrator shall have the following qualifications: 1. Attainment of at least 18 years of age. 2. Knowledge of the requirements for providing the type of care and supervision needed by clients, including ability to communicate with such clients. 3. Knowledge of and ability to comply with applicable law and regulation. 4. Ability to maintain or supervise the maintenance of financial and other records. 5. Ability to direct the work of others, when applicable. 6. Ability to establish the facility's

			policy, program and budget. 7. Ability to recruit, employ, train, and evaluate qualified staff, and to terminate employment of staff, if applicable to the facility. 8. A baccalaureate degree in psychology, social work or a related human services field and a minimum of one year experience in the management of a human services delivery system; or three years experience in a human services delivery system including at least one year in a management or supervisory position and two years experience or training in one of the following: A. Care and supervision of recipients in a licensed adult day care facility, adult day support center or an adult day health care facility. B. Care and supervision of one or more of the categories of persons to be served by the center. The licensee must make provision for continuing operation and carrying out of the administrator's responsibilities during any absence of the administrator by a person who meets the qualification of an administrator. Title 17, CCR, § 54342(a)(4). Title 22, CCR, §§ 80064 and 82064.
Child Day Care Facility	Health and Safety Code §§ 1596.90 – 1597.621 An appropriate business license as required by the local jurisdiction where the agency is located.		The administrator shall have the following qualifications: 1. Attainment of at least 18 years of age. 2. Knowledge of the requirements for providing the type of care and supervision children need and the ability to communicate with such children. 3. Knowledge of and ability to comply with applicable law and regulation. 4. Ability to maintain or supervise the maintenance of financial and other records. 5. Ability to establish the center's policy, program and budget. 6. Ability to recruit, employ, train, direct and evaluate qualified staff. Title 17, CCR, § 54342(a)(16).

			Title 22, CCR, §§ 101151- and 102424.
Respite Facility; Residential Facility	Health and Safety Code §§ 1500-1567.8 An appropriate business license as required by the local jurisdiction where the agency is located.	Adult Family Home Title 17, CCR, §56088 Certified Family Homes; Title 22, CCR, § 88030 Respite may be provided in any of the facility types identified under "Habilitation."	Administrator Requirements - Applies to all community care facilities: • Criminal Record Clearance; • Medical assessment including TB clearance; • Knowledge of requirements for providing the type of care and supervision needed by clients, including ability to communicate with clients; • Knowledge of and ability to comply with applicable laws and regulations; • Ability to maintain or supervise the maintenance of financial and other records; • Ability to direct the work of others; • Ability to establish the facility's policy, program and budget; • Ability to recruit, employ, train, and evaluate qualified staff, and to terminate employment of staff. Administrator Qualifications • At least 21 years of age; • High school graduation or a GED; • Complete a program approved by CCLD that consists of 35 hours of classroom instruction ○ 8 hrs. in laws, including resident's personal rights, regulations, policies, and procedural standards that impact the operations of adult residential facilities; ○ 3 hrs. in business operations; ○ 3 hrs. in management and supervision of staff; ○ 5 hrs. in the psychosocial needs of the facility residents; ○ 3 hrs. in the use of community and support services to meet the resident's needs; ○ 4 hrs. in the physical needs of the facility residents; ○ 5 hrs. in the use, misuse and interaction of drugs commonly used by facility residents; ○ 4 hrs. on admission, retention, and assessment procedures;

			• Pass a standardized test, administered by the Department of Social Services with a minimum score of 70%. For a capacity of 7 - 15 clients - • 1 year work experience in residential care. Out of home respite: Title 17, CCR, § 54342(a)(58). Respite Facility: Title 17, CCR § 54342(a)(72)
Vouchered Respite Care	No state licensing category. An appropriate business license as required by the local jurisdiction where the agency is located.	First Aid and/or CPR if required in the recipient's service plan	Vouchered respite care must be provided by an individual who (a) is at least 18 years of age or (b) possesses the skill, training, or education necessary to provide the respite service. To the extent that the individual's specialized support needs require additional training or certification in such things as First Aid, Cardiopulmonary Resuscitation (CPR), etc., these needs and requirements will be included as part of the description of respite care needs in the individual's plan of care. Respite may also be provided by an agency that meets the criteria specified in Section 54342 (a)(38). For out-of-home respite services, a facility which meets the standards specified in Section 54342(a)(58) or (72). Title 17, CCR § 54355(g)(4)

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
All respite providers	Vendored by the regional center in accordance with Title 17, CCR, §§ 54310 and 54326	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Licensed Community Care Facilities	Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers	Annually

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title from the options for HCBS State plan services in*

Attachment 4.19-B):	
Service Title:	**Personal Care Services**
Service Definition (Scope):	
Personal Care Services may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/herself. Such assistance most often relates to performance of ADLs and IADLs. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services. 1915(i) Personal Care Services will be a continuation of services beyond the amount, duration and scope of the Personal Care Services Program or In-Home Supportive Services Plus State Plan benefit.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☑	Categorically needy *(specify limits):*
	1915(i) Personal Care Services will be a continuation of services beyond the amount, duration and scope of the Personal Care Services Program or In-Home Supportive Services Plus State Plan benefit.
☐	Medically needy *(specify limits):*

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

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Personal Assistance	No state licensing category. An appropriate business license as required by the local jurisdiction where the agency is located.		Provides personal assistance and support to ambulatory and non-ambulatory recipients.
Assistive Technology Vehicle Modification and Adaptations	No state licensing category.	Registration with the California Department of Consumer Affairs, Bureau of Automotive Repairs.	Providers shall be competent to meet applicable standards of installation, repair, and

	An appropriate business license as required by the local jurisdiction where the agency is located.		maintenance of vehicle adaptations and shall also be authorized by the manufacturer to install, repair, and maintain such systems where possible.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Personal Assistance	Vendored by the regional center in accordance with Title 17, CCR §§ 54310 and 54326.	Upon application for vendorization
Assistive Technology Vehicle Modification and Adaptations	Vendored by the regional center in accordance with Title 17, CCR §§ 54310 and 54326.	Upon application for vendorization

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title from the options for HCBS State plan services in Attachment 4.19-B):*

Service Title: **Homemaker**

Service Definition (Scope):

Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities. 1915(i) Homemaker services will be a continuation of services beyond the amount, duration and scope of the Personal Care Services Program or In-Home Supportive Services Plus State Plan benefit.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑	Categorically needy *(specify limits):*
	1915(i) Homemaker services will be a continuation of services beyond the amount, duration and scope of the Personal Care Services Program or In-Home Supportive Services Plus State Plan benefit.
☐	Medically needy *(specify limits):*

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

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Individual	No state licensing category. An appropriate business license as required by the local jurisdiction where the agency is located.		Individual providers of homemaker services shall have the ability to maintain, strengthen, and safeguard the care of individuals in their homes. Title 17, CCR, §54342(a)(33).
Service Agency	No state licensing category. A business license as required by the local jurisdiction where the agency is located.		Title 17, CCR, §54342(a)(34).

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Individual and Service Agency	Vendored by the regional center in accordance with Title 17, CCR §§ 54310 and 54326.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title from the options for HCBS State plan services in Attachment 4.19-B)*:

Service Title:	**Home Health Aide**

Service Definition (Scope):

Services, as ordered by a physician, defined in 42 CFR § 409.45 that may include but not be limited to personal care services, simple dressing changes, assistance with medications, assistance with activities that are directly supportive of skilled therapy services that do not require the skills of a therapist to be safely and effectively performed. 1915(i) Home Health Aide services will be a continuation of services beyond the existing State Plan benefit.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies)*:	
☑	Categorically needy *(specify limits)*:
	1915(i) Home Health Aide services will be a continuation of services beyond the existing State Plan benefit.
☐	Medically needy *(specify limits)*:

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

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Home Health Agency; Home Health Aide	Health and Safety Code §§1725-1742 An appropriate business license as required by the local jurisdiction where the agency is located.	HHA: Medi-Cal certification using Medicare standards, Title 22, CCR, §51217. CHHA: Title 22, CCR, § 74745	HHA: Title 22, CCR, § 74600 et. Seq; Title 17, CCR, §54342(a)(31). Home Health Aide: Complete a training program approved by the Department of Health Care Services and is certified pursuant to Health and Safety Code § 1736.1. CHHA: Title 22, CCR, §§ 74745-74749; Title 17, CCR §54342(a)(32).

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Home Health Agency; Home Health Aide	California Department of Public Health Vendored by the regional center in accordance with Title 17, CCR, §§ 54310 and 54326.	No less than every three years Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title from the options for HCBS State plan services in Attachment 4.19-B):*

Service Title:	**Adult Day Health Care**

Service Definition (Scope):

Services furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. 1915(i) Adult Day Health Care services will be a continuation of services beyond the amount, duration and scope of State Plan benefit.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☑	Categorically needy *(specify limits):*
	1915(i) Adult Day Health Care services will be a continuation of services beyond the amount, duration and scope of State Plan benefit.
☐	Medically needy *(specify limits):*

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

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Adult Day Health Care Center	Health and Safety Code §§1570-1596.5 An appropriate business license as required by the local jurisdiction where the	Title 22, CCR, §54301	Title 22, CCR, §§ 78201-78233 Title 17, CCR, §54342(a)(5).

	agency is located.		

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Adult Day Health Care Center	California Department of Public Health (Licensing) California Department of Aging (Certification) Vendored by the regional center in accordance with Title 17, CCR, §§ 54310 and 54326.	At least every two years At least every two years Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

2. Policies Concerning Payment for State Plan HCBS Furnished by Legally Responsible Individuals, Other Relatives and Legal Guardians. *(Select one):*

○	The State does not make payment to legally responsible individuals, other relatives or legal guardians for furnishing state plan HCBS.	
◉	The State makes payment to *(check each that applies):*	
	☑	**Legally Responsible Individuals.** The State makes payment to legally responsible individuals under specific circumstances and only when the relative is qualified to furnish services. *(Specify (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) in cases where legally responsible individuals are permitted to furnish personal care or similar services, the State must assure and describe its policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual); (c) how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the State's strategies for ongoing monitoring of the provision of services by legally responsible individuals; and, (e) the controls that are employed to ensure that payments are made only for services rendered):*
		Any of the services identified in this SPA may be provided by a recipient's conservator if the conservator meets all specified provider qualifications. The selection of the conservator as a provider will only be done pursuant to applicable law and the assessment and person centered planning process. Regional centers will monitor service provision and payment.
	☑	**Relatives.** The State makes payment to relatives under specific circumstances and only when the relative is qualified to furnish services. *(Specify: (a) the types of relatives who may be paid to furnish such services, and the services they may provide, (b) the specific circumstances under which payment is made; (c) the State's strategies for ongoing monitoring of the provision of services by relatives, and; (d) the controls that are employed to ensure that payments are made only for services rendered):*
		Any of the services identified in this SPA may be provided by a recipient's relative if the relative meets all specified provider qualifications. The selection of the relative as a provider will only be done pursuant to applicable law and the assessment and person centered planning process. Regional centers will monitor service provision and payment.
	☑	**Legal Guardians.** The State makes payment to legal guardians under specific circumstances and only when the guardian is qualified to furnish services. *(Specify: (a) the types of services for which payment may be made, (b) the specific circumstances under which payment is made; (c) the State's strategies for ongoing monitoring of the provision of services by legal guardians, and; (d) the controls that are employed to ensure that payments are made only for services rendered):*
		Any of the services identified in this SPA may be provided by a recipient's legal guardian if the legal guardian meets all specified provider qualifications. The selection of the legal guardian as a provider will only be done pursuant to applicable law and the assessment and person centered planning process. Regional centers will monitor service provision and payment.
	☐	**Other policy.** *(Specify)*:

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. **Election of Participant-Direction**. (*Select one):*

◉	The State does not offer opportunity for participant-direction of state plan HCBS.
○	Every participant in HCBS state plan services (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in HCBS state plan services (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. *(Specify criteria):*

2. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the HCBS State Plan option, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. **Participant-Directed Services**. *(Indicate the HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

4. **Financial Management.** (*Select one):*

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as an administrative function.

5. ☐ **Participant–Directed Service Plan.** The State assures that, based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Is directed by the individual or authorized representative and builds upon the individual's preferences and capacity to engage in activities that promote community life;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual or representative;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques.

6. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

7. **Opportunities for Participant-Direction**

a. Participant–Employer Authority (individual can hire and supervise staff). *(Select one):*

○	The State does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget). *(Select one):*

○	The State does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):*

Quality Management Strategy

(Describe the State's quality management strategy in the table below):

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
Service plans address assessed needs of enrolled participants, are updated annually, and document choice of services and providers.	1. A representative sample of IPPs will be reviewed to ensure all requirements are met. Sample size will depend on total number of recipients. The random sample will represent a 95% confidence level with no more than a 5% margin of error. 2. All recipient's IPPs reviewed at least annually and modified as needed based on each individual's needs.	1. DDS and DHCS 2. Regional centers	1. The representative sample of IPPs will be reviewed to determine that: all assessed needs are addressed; all services received and responsible providers are identified in the IPP and agreed to by the individual; and the IPP is reviewed at least annually and revised when needed 2. Documentation in each individual's record of an (at least) annual IPP review or completion of a new IPP.	1. Yes. Plans to correct all identified deficiencies will be included in final reports. Compliance will be tracked over time to identify trends that may require further intervention.	1. Biennially 2. Annually
Providers meet required qualifications	1. Vendorization by the regional center in accordance with Title 17, CCR, §§ 54310 and 54326	1. Regional centers	1. Provider files maintained at regional center contain, as required: license; certification; program design; and		1. Upon application for vendorization and ongoing thereafter through

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
			staff qualifications.		oversight and monitoring activities.
	2. On-site sample reviews of providers including provider interviews and a health and safety review.	2. DDS and DHCS	2. Providers are interviewed to determine: familiarity with the IPP process and the provider's responsibilities in meeting objectives in the IPP. The setting where services are delivered is reviewed to determine if any health and safety issues are present	2. Yes. Provider reviews will be conducted in conjunction with the DDS/DHCS monitoring of the HCBS Waiver for individuals with developmental disabilities. Plans to address all issues identified will be included in final reports.	2. Random sample of 210 service providers reviewed biennially.
	3. Monitoring of Facilities licensed by DSS-CCLD.	3.a DSS-CCLD	3.a Facilities Automated System tracks annual visit dates. All facilities are reviewed annually to determine compliance with regulations regarding provision of services, health and safety and provider qualifications.	3.a Yes. Evaluation reports identify any deficiencies identified.	3.a Annually

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
		3.b Regional centers	3.b Facility review reports. All residential facilities are reviewed annually. This includes reviewing a random sample of 20% of resident records to determine that services are provided in accordance with the IPP and the provider's service design.	3.b Yes. Annual review reports document any deficiencies noted. Corrective action plans developed as necessary which describe steps needed and timeline for correction.	3.b Annually
		3.c DDS - for facilities certified by DDS	3.c On-site reviews are conducted at all facilities certified by DDS to ensure that regional centers are monitoring the provider's implementation of IPPs.	3.c Yes. Documentation of semi-annual reviews including any deficiencies identified and plans for correction are documented semi-annually for each facility.	3.c Every six months.
	4. Commission on Accreditation of Rehabilitation Facilities (CARF) process for supported employment and pre-	4. CARF	4. Accreditation reports and conformance of quality reports.		4. Within four years initially, then every one to three years.

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
	vocational programs. 5. Monitoring of providers licensed/certified by the California Department of Public Health (CDPH).	5. CDPH; California Department of Aging for Adult Day Health Care Facilities.	5. Certification survey reports verify compliance with applicable laws and regulations.		5. Every two to three years depending on provider type.
The SMA retains authority and responsibility for program operations and oversight.	1. Participation in IPP reviews as described in "service plan" requirement above. 2. Review and approve required reports. 3. Review, negotiate and approve amendment requests for the inter-agency agreement (IA). 4. Review 1915(i) related policies, procedures, and regulations that are developed by and received from DDS.	DHCS	1. Results (described in "service plan" requirement above) of sample IPP reviews. 2. Documentation of report approval 3. IA approval based on compliance with applicable state and federal laws, regulations and policies. 4. Documentation of policy and/or procedure review to ensure compliance with applicable state and federal laws, regulations and		1. Biennially 2. As required 3. As required 4. As required

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
			policies.		
	5. DHCS, along with DDS and DSS-CCLD, conduct regular coordination meetings.		5. Meeting minutes identify compliance issues and resolutions and activities planned to address issues.		5. Quarterly
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to enrolled participants by qualified providers.	1. Fiscal audits of regional centers conducted by DDS.	1. DHCS staff review working papers prepared by DDS audit staff of regional centers on a sample basis.	1. Regional center audit reports identify any fiscal compliance issues with state or federal laws, regulations or policies.	1. Yes. Regional center audit reports include all deficiencies identified and the regional center plans to address the deficiencies.	1. Biennially
	2. Vendor audits conducted by DDS and regional centers.	2. DHCS conducts, on an annual basis, a random sample review of the regional center vendor audit reports.	2. Vendor audit reports.	2. Yes. Vendor audit reports include any deficiencies identified and actions needed to address to address the deficiencies.	2. Ongoing
	3. Review of Independent CPA regional center audits. DDS fiscal audits are designed to wrap around the independent CPA audit to ensure	3. DHCS, DDS	3. Independent CPA audit reports. Independent audits are conducted annually at each regional center		3. Annually

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
	comprehensive financial accountability.				
	4. Verification of recipient eligibility for Medi-Cal	4. DHCS, DDS, Regional Centers	4. Medi-Cal eligibility match, invoice reports.	4. Yes.	4. Monthly
	5. Invoice tracking, payment and reconciliation processes.	5. DHCS	5. Tracking logs verify consistency between payments and invoices.		5. Monthly
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	1. IPPs are developed that address all recipient needs, including health and welfare.	1. Regional centers, DDS, DHCS	1. Results (described in "service plan" requirement above) of sample IPP reviews.	1. Yes. Plans to correct all identified deficiencies will be included in final reports. Compliance will be tracked over time to identify trends that may require further intervention.	1.Biennially
	2. Review of special incident reports (SIRs)	2. DDS, regional centers	2. Incident reports identify appropriate follow-up is taken, including measures to prevent reoccurrence if	2. Yes. Reports are run from the SIR database system to identify issues requiring further analysis and follow-	2. Regional centers review all SIRs daily. DDS reviews a sample of SIRs daily.

	3. Review and analysis of SIR data to identify trends.	3. DDS, independent risk management contractor	possible. 3. DDS and risk management contractor reports. Technical assistance and/or information provided as a result of the analysis. Summary of risk management activities sent to DHCS.	up. 3. Yes. DDS and risk management contractor reports.	3. On-going
Describe the process(es) for remediation and systems improvement.	Consistent with the CMS approved California Quality Management system for the HCBS Waiver for individuals with developmental disabilities, the following describes State's quality management framework which starts with establishing clear expectations for performance (design), collecting and analyzing data to determine if the expectations are met (discovery), and finally, taking steps to correct deficiencies or improve processes and services (remediation and improvement). **Service Plans or individual program plans (IPPs)** Performance expectations (design) in this area include: • Service plans must address all participants' assessed needs (including health and safety risk factors) and personal goals, either by 1915(i) services or through other means. • Service plans are updated/revised when warranted by changes in the participant's needs. • Services are delivered in the type, scope, amount, duration, and frequency and are delivered in accordance with the service plan. • Participants are afforded choice. Data collected (discovery) to determine if expectations are met includes: • DDS and DHCS conduct biennial monitoring reviews of a random, representative sample of service recipient records to ensure service plans meet the expectations identified above. Monitoring will be completed over a two year period with reports produced after reviewing each geographical region				

(regional center). The statewide sample size will produce results with a 95% confidence level and no more than 5% margin of error. For example, with an estimated 40,000 recipients, the sample size would be 381.

- The recipient survey portion of the recently revised Client Development and Evaluation Report (CDER) includes questions regarding the recipient's satisfaction with services.
- Annually, all recipients receive a statement of services and supports purchased by the regional center for the purpose of determining if services were delivered.
- Participation in the National Core Indicators project will provide further data that can be used to measure recipient satisfaction with services and choices.

Steps to correct deficiencies or improve processes and services (remediation and improvement) include:

- Regional centers are required to submit plans to correct all issues identified in the biennial monitoring conducted by DDS and DHCS. These plans are reviewed and approved by the State.
- The data from the monitoring reviews allows for identification of trends in a particular area (e.g. specific requirement or geographical area).
- If any of the monitoring reviews result in a significant level of compliance issues, a follow-up review will be scheduled to evaluate the progress of the corrective actions taken in response to the previous monitoring review.
- Extra training and/or monitoring is provided if issues are not remediated or improvement is not shown.
- DDS' Quality Management Executive Committee (QMEC), also attended by DHCS management, meets quarterly to review data regarding service recipients, explore issues or concerns that may require intervention, and develop strategies and/or interventions for improved outcomes.

Qualified Providers

Performance expectations (design) in this area include:

- DDS sets qualifications for providers through the regulatory process.
- Regional centers, through the vendorization process, verify that each provider meets the required qualifications (e.g. license, program design, staff qualifications) prior to services being rendered.
- DDS developed and funds the Direct Support Professional (DSP) Training program. This is a 70 hour, competency-based program mandatory for all direct service staff working in licensed residential facilities. The program is based upon minimum core competencies staff must have to ensure the health and safety of

	individuals being served. • DSS-CCLD is responsible for licensing community care facilities and day programs and establishes qualifications for providers in those categories. Administrators and applicants/licensees (sometimes one and the same) are required to take a 35-hour course from an approved trainer and pass a written test with a score of 70 percent or above to be a qualified administrator/licensee. There is a two-year re-certification requirement where they need to take an additional 35-hours of training. For each application, they must have a training plan in their facility operational plan for each of the new and continuing staff working in a community care facility. Data collected (discovery) to determine if expectations are met includes: • As part of the biennial DDS/DHCS monitoring of the HCBS Waiver for individuals with developmental disabilities, on-site monitoring of service providers, who also provide 1915(i) services, is conducted. Included in this review, service providers and direct support professionals are interviewed to determine that they are: knowledgeable regarding the care needs on the individual's plan of care for which they are responsible and that these services are being delivered; knowledgeable of and responsive to the health and safety/well-being needs of the consumer(s); and aware of their responsibilities for risk mitigation and reporting. • DSS-CCLD monitors all licensed community care facilities annually to identify compliance issues. Facilities are reviewed to determine compliance with regulations regarding provision of services, health and safety and provider qualifications. • DSP training data is used to not only identify the success rate of staff taking the course, but also in what form (e.g. through classroom setting or challenge test) the course was taken and what areas (written test or skills check) caused failure for those who did not pass the course. • Regional centers also monitor each licensed residential community care facility annually to verify or identify any issues with program implementation. • Special incident report data allows for identification of trends with individual providers or types of providers. • The results of on-site reviews conducted every six months at DDS certified facilities. Steps to correct deficiencies or improve processes and services (remediation and improvement) include: • Regional centers are required to submit plans to correct all issues identified in the biennial monitoring conducted by DDS and DHCS. These plans are reviewed and approved by the State.

	• Any DSS-CCLD monitoring visit that results in a finding of non-compliance results in the development of a plan of correction. This requires follow-up by DSS-CCLD staff to verify that corrections were made. • Issues identified during monitoring visits by regional centers may result in the need to develop a corrective action plan which details the issues identified and the steps needed to resolve the issues. The results of these reviews, as well as data from the special incident report system, are used to identify trends with individual or types of providers which may then result in focused or widespread training or other remediation measures. • DDS' Quality Management Executive Committee (QMEC), also attended by DHCS management, meets quarterly to review data regarding service recipients, explore issues or concerns that may require intervention, and develop strategies and/or interventions for improved outcomes. As an example, data from the special incident report system and analysis by the State's independent risk management indicated that the second largest cause of unplanned hospitalizations was due to psychiatric admissions. In response, the QMEC approved the implementation of skill checks within challenge tests. The skill checks now require staff to demonstrate proficiency in the proper method of assisting individuals in the self-administration of medications. **SMA Programmatic Authority** Performance expectations (design) in this area include: • DHCS and DDS conduct biennial monitoring reviews of a random, representative sample of service recipient records to ensure service plans meet expectations. • DHCS reviews and approves reports developed as a result of these monitoring visits. • DHCS negotiates approval and amendment requests for the interagency agreement with DDS to ensure consistency with federal requirements. • DHCS reviews 1915(i) related policies, procedures and regulations that are developed by DDS to ensure consistency with federal requirements. • DHCS participates, as necessary, in training to regional centers and providers regarding 1915(i) policies and procedures. • DHCS, in conjunction with DDS and DSS-CCLD, holds quarterly meetings. The purpose of these meetings is to discuss issues applicable to licensed providers (community care facilities, day programs.) • DHCS participates in the quarterly DDS Quality Management Executive Committee. The purpose of these meetings is to review data regarding service recipients, explore issues or concerns that may require intervention, and develop strategies and/or interventions for improved outcomes.

	Data collected (discovery) to determine if expectations are met includes: • Results from the biennial monitoring reviews, conducted by DHCS and DDS, of a random, representative sample of service recipient records to ensure service plans meet the expectations identified previously. • Documentation of DHCS approval of monitoring or other required reports. Monitoring reports will also include approved plans submitted in response to findings by DHCS and DDS. • Evidence of training provided as a result of findings from DHCS and DDS monitoring reviews. • Minutes from meetings DHCS participates in documenting issues discussed and resolution activities planned. Steps to correct deficiencies or improve processes and services (remediation and improvement) include: • Regional centers are required to submit plans to correct all issues identified in the biennial monitoring conducted by DHCS and DDS. These plans are reviewed and approved by the State. • If any of the monitoring reviews result in a significant level of compliance issues, a follow-up review will be scheduled to evaluate the progress of the corrective actions taken in response to the previous monitoring review. • Extra training and/or monitoring is provided if issues are not remediated or improvement is not shown. **SMA Maintains Financial Accountability** Performance expectations (design) in this area include: • DHCS reviews a sample of working papers prepared by DDS audit staff of the biennial fiscal audits. These fiscal audits are designed to wrap around the required annual independent CPA audit of each regional center. • DHCS also annually reviews a sample of audits conducted of service providers. • DHCS ensures recipients are eligible for Medi-Cal prior to claims being made. • DHCS maintains invoice tracking, payment and reconciliation processes. Data collected (discovery) to determine if expectations are met includes: • Results of the audit reviews identify fiscal compliance issues.

	• Electronic records and hard copy reports (as needed) are generated identifying recipients eligible for claiming. • Tracking logs verify consistency with between invoices, payments and funding authority. Steps to correct deficiencies or improve processes and services (remediation and improvement) include: • DHCS monitors and provides consultation as necessary regarding corrective actions and follow-up activities resulting from regional center and vendor audits. All issues identified in the audits include corrective action plans which may include policy revisions or repayments if necessary. • DHCS works with DDS to resolve issues, if any, with identifying Medi-Cal eligibility of recipients. **Risk Mitigation** Performance expectations (design) in this area include: • Service plans must address all participants' assessed needs (including health and safety risk factors) and personal goals, either by 1915(i) services or through other means. • DDS, through the regulatory process, has identified requirements for service providers and regional centers regarding reporting of special incidents. Providers must report all special incidents to the regional center within 24 hours. Subsequently, regional centers must report special incidents to DDS within two working days. • DDS has implemented an automated special incident report (SIR) system and database which allows complex analysis of multiple factors to identify trends and provide feedback to regional centers. • DDS provides data from the SIR system to the State's independent risk management contractor for further analysis. • Regional centers must transmit SIRs, including the outcomes and preventative actions taken, to DDS as well as local licensing offices and investigative agencies as appropriate. • Regional centers must develop and implement a risk management and prevention plan. • Regional centers are responsible for using data from the SIR system for identifying trends that require follow-up. • The State's risk management contractor is responsible for reviewing and analyzing DDS SIR data to identify statewide, regional and local trends requiring action. This includes defining indicators of problems requiring further inquiry. Additionally, the contractor performs ongoing review and analysis of the research and current literature with respect to preventing accidents, injuries and other adverse incidents.

	Data collected (discovery) to determine if expectations are met includes: • DDS and DHCS conduct biennial monitoring reviews of a random, representative sample of service recipient records to ensure service plans address health and safety risk factors. • The recipient survey portion of the CDER includes questions regarding the recipient's feelings of safety, availability of assistance if needed, and access to medical care. • Data from the SIR system includes recipient characteristics, risk factors, residence, responsible service provider and other relevant information. This data is updated daily and is available not only to DDS but also to regional centers for reviewing data of incidents in their area. • As part of the biennial DDS/DHCS monitoring of the HCBS Waiver for individuals with developmental disabilities, information is gathered regarding the regional center's risk management system. Additionally, information is obtained reflecting how the regional center is organized to provide clinical expertise and monitoring of individuals with health issues, as well as any improvement in access to preventative health care resources. Steps to correct deficiencies or improve processes and services (remediation and improvement) include: • Regional centers are required to submit plans to correct all issues identified in the biennial monitoring conducted by DDS and DHCS. These plans are reviewed and approved by the State. • If any of the monitoring reviews result in a significant level of compliance issues, a follow-up review will be scheduled to evaluate the progress of the corrective actions taken in response to the previous monitoring review. • DDS uses data from the SIR system to identify compliance issues such as reporting timelines and notifications of other agencies if required. Contact is made with regional centers for correction. Training or technical assistance is provided if necessary. • Utilizing results of data analysis from the SIR system, the State's risk management contractor conducts a variety of activities, including: develop and disseminate periodic reports and materials on best practices related to protecting and promoting the health, safety, and well-being of service recipients; provide on-site technical assistance to regional centers related to local risk management plans and activities; define indicators requiring further inquiry. • The risk management contractor also develops and maintains a website, (www.ddssafety.net) for recipients and their families, providers, professionals, and regional center staff. This web site is dedicated to the dissemination of information on the prevention and mitigation of risk factors for persons with

	developmental disabilities. The site includes information from across the nation on current research and best practices and practical information directed towards improving health and safety.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☑	Habilitation	
	☑	Foster Family Agency/Certified Family Homes
		Rates are established by the State using the Alternative Residential Rate Model for the associated level of service.
	☑	Foster Family Homes
		Rates are established by the State using the Alternative Residential Rate Model for the associated level of service.
	☑	Small Family Homes
		Rates are established by the State using the Alternative Residential Rate Model for the associated level of service.
	☑	Group Homes
		Rates are established by the State using the Alternative Residential Rate Model for the associated level of service.
	☑	Residential Facilities for Adults or Residential Facility for the Elderly
		Rates are established by the State using the Alternative Residential Rate Model for the associated level of service.
	☑	Family Home Agency/Adult Family Home
		Rates are established by the State using the Alternative Residential Rate Model for the associated level of service.
	☑	Residential Services – Out of State
		Established rate based on services and supports provided.
	☑	Specialized Residential Facilities (DSS Licensed)
		Statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Supplemental Residential Program Support
		Statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Supported Living Services
		Statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Mobility Training Services Agency
		Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Mobility Training Services Specialist
		Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.

	☑	Adaptive Skills Trainer
		Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Socialization Training Program
		Statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Community Integration Training Program: Agency
		Statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Community Activities Support Services: Individuals
		Statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Activity Center
		Rates set by cost statement pursuant to State regulatory requirements.
	☑	Adult Development Centers
		Rates set by cost statement pursuant to State regulatory requirements.
	☑	Behavior Management Program
		Rates set by cost statement pursuant to State regulatory requirements.
	☑	Independent Living Program
		Rates set by cost statement pursuant to State regulatory requirements.
	☑	Independent Living Specialist
		Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Individual (Day Habilitation-Supplemental Day Services Program Support)
		Statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Agency (Creative Art Program)
		Statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Developmental Specialist
		Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Community Rehabilitation Program (Supported Employment)
		Rates set by statute
	☑	Community Rehabilitation Program (Pre-Vocational Services, Work Activity Program)
		Rates set by cost statement pursuant to State regulatory requirements.
	☑	In-home Day Program
		Statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.

	☑	Crisis Team-Evaluation and Behavioral Intervention
		Statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Client/Parent Support Behavior Intervention Training
		Statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Crisis Intervention Facility
		Statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Behavior Analyst
		Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Associate Behavior Analyst
		Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Behavior Management Assistant
		Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Behavior Management Consultant
		Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	HCBS Personal Emergency Response Systems
		Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
☑	Respite Care	
	☑	Respite-Individual
		Rates set by regulation
	☑	Respite-Service Agency
		Rates set by cost statement pursuant to State regulatory requirements.
	☑	Adult Day Care Facility
		Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.

	☑	Child Day Care Facility
		Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Respite Facility; Residential Facility
		Rates set based on the Alternative Residential Rate Model.
	☑	Vouchered Respite Care
		Rates set by regulation
☑	HCBS Personal Care	
	☑	Personal Assistance
		Statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☐	HCBS Personal Care I
	☐	HCBS Personal Care II
	☐	HCBS Attendant Services
	☐	HCBS Adult Companion
	☑	HCBS Assistive Technology - Vehicle Modification and Adaptation
		Usual and Customary Rates i.e. the rate which is charged to the general public.
☑	HCBS Homemaker	
	☑	Basic Homemaker – Individual
		Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
	☑	Basic Homemaker – Agency
		Either 1) usual and customary rates (i.e., the rate which is charged to the general public) or 2) statute mandates that rates may not exceed the regional center's median rate or the statewide median rate, whichever is lower.
☑	HCBS Home Health Aide	
	☑	Home Health Agency
		Rates are set according to the Schedule of Maximum Allowances (SMA) -- the schedule of the maximum allowable rate for the service provided as established by the Department of Health Care Services for services reimbursable under the Medi-Cal program.

	☑	Home Health Aide
		Rates are set according to the Schedule of Maximum Allowances (SMA) -- the schedule of the maximum allowable rate for the service provided as established by the Department of Health Care Services for services reimbursable under the Medi-Cal program.
☑	Adult Day Health Care	
	Rates are set according to the Schedule of Maximum Allowances (SMA) -- the schedule of the maximum allowable rate for the service provided as established by the Department of Health Care Services for services reimbursable under the Medi-Cal program.	

For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

2. **Presumptive Eligibility for Assessment and Initial HCBS.** Period of presumptive payment for HCBS assessment and initial services, as defined by 1915(i)(1)(J) *(Select one):*

◉	The State does not elect to provide for a period of presumptive payment for individuals that the State has reason to believe may be eligible for HCBS.
○	The State elects to provide for a period of presumptive payment for independent evaluation, assessment, and initial HCBS. Presumptive payment is available only for individuals covered by Medicaid that the State has reason to believe may be eligible for HCBS, and only during the period while eligibility for HCBS is being determined. The presumptive period will be _____ days (not to exceed 60 days).

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

MAR 2 6 2010

Toby Douglas
Chief Deputy Director of Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Mr. Douglas:

We have reviewed the proposed amendment to the California Medicaid State plan submitted to the Centers for Medicare and Medicaid Services (CMS) on December 30, 2009 as State plan amendment (SPA) 09-023. This SPA proposes to add services under Section 1915(i) of the Social Security Act (Act) to Attachment 3.1-C of the State plan and corresponding reimbursement methodologies under Attachment 4.19-B. Based on our review of the SPA and several discussions with California Department of Health Care Services staff, we find that additional information is needed before we can approve this amendment. We are requesting the below additional information pursuant to the Section 1915(f)(2) of the Act.

General:

1. Public Notice – Please provide the public notice information for this State Plan Amendment.

2. Please make the following changes to the CMS-179:
   a. In Type of Plan Material, please correct the box to indicate that this is an Amendment to the State plan.
   b. Please include the Federal Statute/Regulation Citation that governs the changes proposed by this SPA in Box 6.
   c. Please provide the Federal Budget Impact and explain how the amounts were determined in Box 7.
   d. Please indicate the submission date.

3. Please describe if and how the State consulted with Indian Health Programs, including the Indian Health Service, Tribes, Tribal Organizations, and Urban Indian Organizations on the impact of this SPA. Please refer to the State Medicaid Director Letter 10-001 dated January 22, 2010 for more information about the tribal consultation requirements.

Coverage – Attachment 3.19-C:

General

1. Section 6086 of the Deficit Reduction Act (2005) allows for the provision of home and community-based services for individuals with less than an institutional level of care under Section 1915(i) authority. The State may use needs-based criteria and risk factors to ensure that services reach the intended population, e.g. people with developmental disabilities. However these services must be made available to all individuals who meet these criteria regardless of diagnosis or delivery system.

Administration and Operation

2. Pg. 1, #3 – The State indicated the operating agency for the HCBS State Plan Services is the Department of Developmental Services (DDS). Please explain how the State intends to provide the services to eligible beneficiaries absent a developmental disability. Revise the function distribution chart on page 4 as appropriate.

Needs-Based Evaluation/Reevaluation

3. Pg. 4, #1 – Please explain how the State will provide for evaluations/re-evaluations for individuals served outside the Regional Centers without developmental disabilities. Assure that the qualifications of the providers performing this function take into account all individuals who may meet the needs-based and risk criteria.

4. Pages 4 & 5, #4 – The needs-based eligibility criteria should be described first (e.g. "the individual has a need for assistance…". Regarding the proposed risk factors, as noted previously, the State must clearly explain appropriate risk factors in lieu of the proposed language.

5. Page 6, #5 – Please clarify and revise the proposed *Differences Between Level of Care Criteria* chart to reflect the revised needs-based criteria and risk factors, especially the section on State Plan HCBS Needs-based eligibility criteria. Also, the State needs to more specifically summarize the criteria in the nursing facility column.

6. Page 8, #8 – Please add language indicating that HCBS settings are not ICFs/MR. Please also include additional details regarding how the home-like nature of a residential setting is determined (e.g. free access to food, visitors, lockable doors, etc.). Are all the facilities listed as providers serving four people or fewer, including the out-of-State facilities?

Person-Centered Planning and Service Delivery

7. Page 9, #3 and #4 – Does the State allow experience in fields other than developmental disabilities to substitute for educational qualifications?

8. Page 9, #5 – Please revise this text as it appears to address only the needs of people with developmental disabilities. When an "individual is assigned a case manager," does he/she

have the opportunity to freely choose from among qualified case managers? Please also describe in detail how the eligible beneficiary can determine who is included in the service planning process and how providers participate in this process for a new enrollee. Also, please address how service planning meetings are scheduled at times and locations that are convenient to the participant.

9. Page 10, #7 – Please add language to indicate that the sample of service plans to be annually reviewed (not necessarily IPPs) is representative.

10. Page 10, #7 and 8 – How can DDS, "in conjunction with DHCS," be the only agency with IPPs on file, provided the State adjusts its needs-based/risk criteria? Similarly, how can the Regional Centers be the only entity to house service plans?

Services & Provider Qualifications

11. Page 11, Habilitation, general description – Based on provider qualifications, it appears that a specific behavioral habilitation component is included in the Habilitation service. If so, it should be a separate component service under Habilitation, with an appropriate rate methodology. It also appears that mobility training is a separate component of Habilitation (eg. Mobility Habilitation Training).

12. Habilitation, general – With regards to provider types, please explain how all Habilitation services are available to people without developmental disabilities (e.g. creative art program). Please also include complete information with regards to specific licensing and certification requirements for all providers. Some sections are blank, while others simply list business license.

13. Habilitation, general – Please add a statement indicating that any services provided to family members are for the benefit of the HCBS recipient

14. Page 11, Home-Based Habilitation – What type of HCBS "facility" would be required to meet the Life Safety Code requirements? Are the descriptions of the types of Supported Employment (Group, Individual, Pre-Vocational, Supported Habilitation) inclusive of the language cited in the California Welfare and Institutions Code? Regarding the Supported Employment service and the Pre-vocational services, the State should delete any language limiting the service to people 18 years of age, or older, since Section 1915(i) of the Act does not provide for such a limitation. Also, all the language in this section should be changed to indicate the service description is inclusive of a set of services, rather than "includes" certain services. The State may wish to complete the section for additional needs-based criteria for receiving the Habilitation service.

15. Page 14, Foster Family Homes – Please add a statement indicating payment for services will not be duplicated or supplanted through Medicaid funding.

16. Page 16 – Please explain how Regional Centers vendorize for the purposes of this State Plan Amendment.

17. Page 17 – Please provide more detail about the Specialized Residential Facilities (DDS Licensed) and the Residential Facilities (Supplemental Program Support).

18. Page 17 – Regarding the incidental services provided by a "DSS-Licensed Specialized Residential Facility," how are these services (home health care, physical therapy, occupational therapy, etc.) funded?

19. Page 21, Infant Development Program – Please explain the intersection with IDEA, and verify non-duplication of services. How does the applicable prohibition on services delivered through the Individuals with Disabilities Education Improvement Act (IDEA) and Section 110 of the Rehabilitation Act of 1973 in Section 1915(i) impact any services provided through the SPA?

20. Page 26, Respite Care – Are there any mechanisms in place for individuals not served by the Regional Centers to procure vouchered respite care? The State should complete the applicable self-direction portion of the template for this service.

21. Page 27 – Under "Specify Limits," the State should clarify that home respite may be provided outside the dispensation of a Regional Center.

22. Page 30 – Regarding the Provider Qualifications, how can all providers be vendored by a Regional Center?

23. Page 31, Personal Care – The provider qualifications indicate this service includes vehicle adaptations. Please explain. Also, Personal Emergency Response Systems are likely more appropriate as a Habilitation service. In limits on the service, please indicate that personal care services will be a continuation of services beyond the amount, duration and scope of the regular State plan benefit. Regarding the provider qualifications, please explain how all providers can be vendored by a Regional Center.

24. Page 33, Homemaker – In limits on the service, please indicate that this services will be a continuation of services beyond the amount, duration and scope of the regular State plan personal care benefit. Also, please explain how all providers can be vendored by a Regional Center?

25. Page 34 – Please note that Home Health Aide services will be a continuation of services beyond the amount, duration and scope of the regular State plan benefit. How can all providers be vendored by a Regional Center?

26. Page 35 – Please clarify the intersection of the Adult Day Health Care service with the present configuration in the approved State plan. Is transportation included in the regular benefit? Also, please specify limits on this service and note that services would be a continuation of services beyond the amount, duration and scope of the regular State plan benefit.

27. Page 36, Case Management – The SPA indicates that case management is provided through the TCM State Plan benefit. What target groups are included in the State plan that may be

served through this amendment? Regarding the provision of "any" service by a recipient's conservator, legal guardian, or relative, please explain how only the Regional Centers would monitor this arrangement. Since case management is not a State plan HCBS service, please remove case management from the services section.

Quality Improvement Strategy

28. Page 40 – Please reconfigure this chart based on the need to expand the group of individuals who can receive the HCBS State plan services. This includes revising the "who" and "what" in the Monitoring Activities and Monitoring Responsibilities sections. Under Evidence, the State needs to articulate what "results" will serve as sound evidence. The Evidence section must also include documentation that samples are representative for all requirements, including confidence intervals and sample size. Please explain what sort of monitoring reports will be used to assess the adequacy of service plans and how these reports will be evaluated. Regarding the verification of provider qualifications, elaborate on the Data Elements associated with each of the monitoring activities. Please describe what sort of oversight DHCS will impose on the various agencies required to track whether or not providers meet provider qualifications. CMS urges the State to avail itself of technical assistance from our NQE contractor to strengthen this section (http://nationalqualityenterprise.net/), including the section on remediation and systems improvement, and how the State evaluates the effectiveness of system changes.

Reimbursement – Supplement 13 to Attachment 4.19-B:

Even though the State included brief descriptions of how payment rates are set for each provider type for each 1915(i) service under Attachment 3.1-C, Methods and Standards for Establishing Payment Rates, the State must include the details of each reimbursement methodology under Attachment 4.19B. The Attachment 4.19-B pages submitted with this SPA do not contain the reimbursement methodology related to the covered services.

42 CFR 430.10 and 447.252 require that the State plan contain a comprehensive description of the rate methodologies for Medicaid services. To be in compliance with Federal regulations and CMS policy, the State needs to incorporate the details of the reimbursement methodology(ies) for each service into Attachment 4.19B. Specially, the State plan should specify the following:

a. For each service, if a different reimbursement methodology is used based on the provider type, define the providers eligible for each specific methodology.

b. The details of each methodology. If it is based on a fee schedule, the State needs to include both the effective date and a reference to where the fee schedule can be located. If another methodology is used, please include detailed steps that explain how the reimbursement rate is determined. These details must include, but are not limited to, the cost principles and the cost reporting tool used to identify allowable costs, the process by which allowable costs are apportioned to the Medicaid populations, details of how indirect costs and/or rates are determined and applied, any interim/final payments and reconciliations, state cost report audit/settlement process and the source of program and cost data.

Standard Funding Questions:

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

3. 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. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

We are requesting this additional clarifying information under provisions of Section 1915(f) of the Social Security Act (added by P.L. 97-35). This request has the effect of stopping the 90-day clock for CMS to take further action on the State Plan submittal. A new 90-day clock will begin when we receive your complete response to this request for additional information. In accordance with our guidelines to all State Medicaid Directors, dated January 1, 2001 we request that you provide a formal response within 90 days from the date of this letter. Thank you in advance for you cooperation in processing this SPA.

If you have any questions, please contact Cynthia Nanes at (415) 744-2977 or at Cynthia.Nanes@cms.hhs.gov.

Sincerely,

Gloria Nagle

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Paul Miller, Division of Long-Term Care, CA DHCS
Ellen Blackwell, CMS, CMSO
Kathy Poisal, CMS, CMSO
Beverly Binkier, CMS, RO