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: **12-020**

2. STATE: CA

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
April 1, 2012

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:
Section 1915(i) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 12 $5.3 million
b. FFY 13 $6.8million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

ATTACHMENT 3.1C pages 117-160
ATTACHMENT 4.19 B pages 76-78

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

NONE

10. SUBJECT OF AMENDMENT:
Participant Self-Directed 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:
Director

15. DATE SUBMITTED: 6/29/12

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, MS 4506
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
TOBY DOUGLAS
Director

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

EDMUND G. BROWN JR.
Governor

JUN 2 9 2012

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Dear Ms. Nagle:

The Department of Health Care Services (DHCS) is submitting the enclosed State Plan Amendment (SPA) 12-020, which provides Medi-Cal eligible persons with developmental disabilities with the opportunity to self-direct some home and community-based services. SPA 12-020 also includes Financial Management Services for these individuals.

In compliance with the new policy set forth by the American Recovery and Reinvestment Act of 2009 (ARRA), on May 15, 2012, DHCS notified Indian Health Programs and Urban Indian Organizations of SPA 12-020. As of the date of this letter, no comments have been received from Indian Health Programs and Urban Indian Organizations.

I want to express the Department's appreciation for the technical assistance and guidance that CMS's regional and central office staffs have provided us on Section 1915(i). Their input has proved invaluable to crafting our program to provide home and community-based services to Medi-Cal eligible persons with developmental disabilities.

Sincerely,

Toby Douglas
Director

Enclosures

Director's Office
1501 Capitol Avenue, MS 0000, P.O. Box 997413, Sacramento, CA 95899-7413
(916) 440-7400, (916) 440-7404 fax
Internet Address: www.dhcs.ca.gov

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

REIMBURSEMENT METHODOLOGY FOR COMMUNITY-BASED TRAINING SERVICES

The maximum rate for this service is set in State statute [Welfare and Institutions Code Section 4688.21(c)(7)] at $13.47 per hour.

REIMBURSEMENT METHODOLOGY FOR RESPITE CARE (PARITICIPANT-DIRECTED)

Rate set in State Regulation – This rate applies to individual respite providers. Per Title 17 CCR, Section 57332(c)(3), the rate for this service is $10.71 per hour. This rate is based on the current California minimum wage of $8.00 per hour plus $1.17 differential (retention incentive) plus Mandated Employer Costs (MEC) of 16.76%. The MEC is comprised of Social Security (6.20%), Medicare (1.45%), Federal Unemployment (0.80%), State Unemployment (4.40%) and Worker's Compensation (3.91%).

For family support respite, there are two rate setting methodologies:

1) The Usual and Customary Rate Methodology – Per California Code of Regulations (CCR), Title 17, Section 57210(a)(19), a usual and customary rate "means the rate which is regularly charged by a vendor for a service that is used by both regional center consumers and/or their families and where at least 30% of the recipients of the given service are not regional center consumers or their families. If more than one rate is charged for a given service, the rate determined to be the usual and customary rate for a regional center consumer and/or family shall not exceed whichever rate is regularly charged to members of the general public who are seeking the service for an individual with a developmental disability who is not a regional center consumer, and any difference between the two rates must be for extra services provided and not imposed as a surcharge to cover the cost of measures necessary for the vendor to achieve compliance with the Americans With Disabilities Act." If the provider does not have a "usual and customary" rate, then the maximum rate is established using the median rate setting methodology.

2) Median Rate Methodology - This methodology requires that rates negotiated with new providers may not exceed the regional center's current median rate for the same service, or the statewide current median rate, whichever is lower. This methodology is defined in California Welfare and Institutions Code section 4691.9(b) which stipulates that "no regional center may negotiate a rate with a new service provider, for services where rates are

determined through a negotiation between the regional center and the provider, that is higher than the regional center's median rate for the same service code and unit of service, or the statewide median rate for the same service code and unit of service, whichever is lower. The unit of service designation must conform with an existing regional center designation or, if none exists, a designation used to calculate the statewide median rate for the same service." While the law sets a cap on negotiated rates, the rate setting methodology for applicable services is one of negotiation between the regional center and prospective provider. Pursuant to law and the regional center's contracts with the Department of Developmental Services regional centers must maintain documentation on the process to determine, and the rationale for granting any negotiated rate (e.g. cost-statements), including consideration of the type of service and any education, experience and/or professional qualifications required to provide the service.

REIMBURSEMENT METHODOLOGY FOR NON-MEDICAL TRANSPORTATION (PARITICIPANT-DIRECTED)

The maximum rate paid to individual transportation provider is established as the travel rate paid by the regional center to its own employees.

REIMBURSEMENT METHODOLOGY FOR SKILLED NURSING (PARITICIPANT-DIRECTED)

The rates for skilled nursing are determined by the "Schedule of Maximum Allowances (SMA)." State regulations define the SMA as the current rate established by the single-state Medicaid agency for services reimbursable under the Medi-Cal program. The SMA is the maximum amount that can be paid for the service. For providers who have a usual and customary rate that is less than the SMA, the regional center shall pay the provider's usual and customary rate.

REIMBURSEMENT METHODOLOGY FOR FINACIAL MANAGEMENT SERVICES

Rates for FMS are set in State regulation, Title 17, CCR, Section 58888(b) as follows:

If the FMS functions as a fiscal/employer agent, the rate is based on the number of participant-directed services used by the consumer:

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- (A) A rate not to exceed a maximum of $45.00 per consumer per month for one participant-directed service; or
- (B) A rate not to exceed a maximum of $70.00 per consumer per month for two or three participant-directed services; or
- (C) A rate not to exceed a maximum of $95.00 per consumer per month for four or more participant-directed services.

If the FMS functions as a co-employer, the rate is not to exceed a maximum of $95.00 per consumer per month for one to four co-employer services.

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1915(i) HCBS State Plan Services
Administration and Operation

1. Program Title (*optional*): California 1915(i) HCBS State Plan Participant-Directed 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):

This 1915(i) SPA employs an Organized Health Care Delivery System (OHCDS) arrangement. The Department of Developmental Services (DDS) is the OHCDS.

DDS Meets the Regulatory Definition of an OHCDS. Federal Medicaid regulations define an OHCDS as "a public or private organization for delivering health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization." 42 C.F.R. § 447.10(b). The term OHCDS is "open to interpretations broad enough to apply to systems which are not prepaid organizations." See State Medicaid Directors dated December 23, 1993. An OHCDS "must provide at least one service directly (utilizing its own employees, rather than contractors)." *Id.* "So long as the entity continues to furnish at least one service itself, it may contract with other qualified providers to furnish Medicaid covered services." *Id.*

There are adequate safeguards to ensure that OHCDS subcontractors possess the required qualifications and meet applicable Medicaid requirements e.g. maintenance of necessary documentation for the services furnished. . Under state law, regional centers are responsible for ensuring that providers meet these qualifications.

The OHCDS arrangements preserve participant free choice of providers. Free choice of providers is a hallmark of the California system. Recipients of 1915(i) services select their providers through the person centered planning process orchestrated by the regional centers, which culminates in the development of an individual program plan (signed by the beneficiary) delineating the services to be provided and the individual's choice of provider of such service(s). If an individual's choice of provider is not vendorized, they must go through the regional center vendorization process to ensure that they meet all necessary qualifications. If a provider meets the qualifications, the regional center must accept them as a vendored provider in the OHCDS.

1915(i) providers are not required to contract with an OHCDS in order to furnish services to participants. Although the open nature of the OHCDS means that virtually all providers will be part of the OHCDS, in the event a provider does not want to affiliate with the OHCDS and regional center, they may go directly to the Department of Health Care Services to execute a provider agreement. However, under state law, the process for qualifying a vendor to provide home-and-community based services to an individual with developmental disabilities is through the regional center.

The OHCDS arrangement provides for appropriate financial accountability safeguards.
According to the State Medicaid Manual, when utilizing an OHCDS to provide waiver services, payment is made directly to the OHCDS and the OHCDS reimburses the subcontractors. Providers of 1915(i) SPA services submit claims to the regional center for services delivered to the beneficiary, pursuant to the individual program plan. The regional center reviews the claim (units of service, rate, etc), pays legitimate claims, and submits the claim of payment to DDS as the OHCDS. The OHCDS reimburses the regional center for the actual cost of the service, certifies the expenditures and submits a claim for the federal financial participation to the Department of Health Care Services. DDS does not "add on" to the actual costs of services incurred by and reimbursed to the regional centers.

The costs for administrative activities are not billed as part of the OHCDS payment and are claimed separately at the appropriate administrative rate.

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	1/1/2012	9/30/2012	4,000
Year 2	10/1/2012	9/30/2013	4,200
Year 3			
Year 4			
Year 5			

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):*

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; 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.

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 as follows:

Welfare and Institutions Code 4512. *As used in this division:*
(a) "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature…
(l) "Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:
(1) Self-care.
(2) Receptive and expressive language.
(3) Learning.
(4) Mobility.
(5) Self-direction.
(6) Capacity for independent living.
(7) Economic self-sufficiency.

Title 17, CCR, §54000. Developmental Disability.
(a) "Developmental Disability" means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.
(b) The Developmental Disability shall:
(1) Originate before age eighteen;
(2) Be likely to continue indefinitely;
(3) Constitute a substantial disability for the individual as defined in the article.
(c) Developmental Disability shall not include handicapping conditions that are:
(1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.
(2) Solely learning disabilities. A learning disability is a condition which manifests as a significant

discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.
(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation.

Title 17, CCR, §54001. Substantial Disability.
(a)"Substantial disability" means:
(1) 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; and
(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:
(A) Receptive and expressive language;
(B) Learning;
(C) Self-care:
(D) Mobility:
(E) Self-direction;
(F) Capacity for independent living;
(G) Economic self-sufficiency.
(b) The assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines and shall include consideration of similar qualification appraisals performed by other interdisciplinary bodies of the Department serving the potential client. The group shall include as a minimum a program coordinator, a physician, and a psychologist.
(c) The Regional Center professional group shall consult the potential client, parents, guardians/conservators, educators, advocates, and other client representatives to the extent that they are willing and available to participate in its deliberations and to the extent that the appropriate consent is obtained.

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 Among 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 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,	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, 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	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 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.	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

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;
 	
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.
	decubiti;
	
	• Administration of medical gases		

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. Private or semi-private bedrooms shared by no more than two persons with personal décor. The choice of residential settings, including making decisions regarding sharing a bedroom, is made during the person-centered planning process.

2. Private or semi-private bathrooms. The residence must have enough bathroom space to ensure residents' privacy for personal hygiene, dressing, etc.

3. Common living areas or shared common space for interaction between residents, and residents and their guests.

4. Residents must have access to a kitchen area at all times.

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

6. Services which meet the needs of each resident.

7. Assurance of residents rights: a) to be treated with respect; b) choose and wear their own clothes; c) have private space to store personal items; d) have private space to visit with friends and family; e) use the telephone with privacy; f) choose how and with whom to spend free time; and h) have opportunities to take part in community activities of their choice.

Residential settings that contain multiple independent living units (e.g. apartments) are considered home-like settings for the purposes of 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 services/supports;
   - 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):*

   The service plan, commonly referred to as the individual program plan (IPP), is prepared jointly by the planning team, which at minimum includes the individual or, as appropriate their parents, legal guardian or conservator, or authorized representative and a representative from the regional center. When invited by the individual, others may join the planning team.

The IPP is developed through a person-centered process of individualized needs determination with the opportunity for active participation by the individual/representative in the plan development and takes into account the individual's needs and preferences. Person-centered planning is an approach to determining, planning for, and working toward the preferred future of the individual and her or his family. Decisions regarding the individual's goals, services and supports included in the IPP are made by agreement of the planning team.

a) *the supports and information made available* –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* – As noted above, 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/parent/representative, 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. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	**Community-Based Training Service**
Service Definition (Scope)*:*	
Community-based training service is a participant-directed service that allows recipients the opportunity to customize day services to meet their individualized needs. As determined by the person-centered individual program planning process, the service may include opportunities and assistance to: further the development or maintenance of employment and volunteer activities; pursue post secondary education; and increase recipients' ability to lead integrated and inclusive lives.	
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):*
	Community-based training services are limited to a maximum of 150 hours per quarter.
☑	Medically needy *(specify limits):*
	Community-based training services are limited to a maximum of 150 hours per quarter.

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Community-Based Training Provider	As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Providers of community-based training service shall be an adult who possesses the skill, training, and experience necessary to provide services in accordance with the individual program plan.

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):*
Community-Based Training Provider	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title	Verified upon application for vendorization and ongoing thereafter

	17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	through oversight and monitoring activities.

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

☑	Participant-directed	☐	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title: **Respite Care (Participant Directed)**

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 temporary absence of family members;
3. Temporarily 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 may only be provided when the care and supervision needs of a consumer exceed that of a person of the same age without developmental disabilities.

Respite also includes the following subcomponent:

Family Support Respite – Regularly provided care and supervision of children, for periods of less than 24 hours per day, while the parents/primary non-paid caregiver are out of the home.

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 may be provided in the following locations:

- Private residence
- Adult Day Care Facility
- Child Day Care Facility
- Licensed Preschool

A regional center may offer vouchers to family members or adult consumers to allow the families and consumers to procure their own respite services.

Respite services do not duplicate services provided under the Individuals with Disabilities Education Act (IDEA) of 2004.

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):*

A consumer may receive up to 21 days of out-of-home respite services in a fiscal year, and up to 90 hours of in-home respite in a quarter unless it is demonstrated that the intensity of the consumer's care and supervision needs are such that additional respite is necessary to maintain the consumer in the family home, or there is an extraordinary event that impacts the family member's ability to meet the care and supervision needs of the consumer. These limits do not apply to family support respite.

☑ Medically needy *(specify limits):*

A consumer may receive up to 21 days of out-of-home respite services in a fiscal year, and up to 90 hours of in-home respite in a quarter unless it is demonstrated that the intensity of the consumer's care and supervision needs are such that additional respite is necessary to maintain the consumer in the family home, or there is an extraordinary event that impacts the family member's ability to meet the care and supervision needs of the consumer. These limits do not apply to family support respite.

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. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	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.
Adult Day Care Facility	Health and Safety Code §§ 1500 - 1567.8 As appropriate, a business license as	N/A	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

	required by the local jurisdiction where the business is located.		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.
Camping Services	As appropriate, a business license as required by the local jurisdiction where the business is located.	The camp submits to the local health officer either 1) Verification that the camp is accredited by the American	Camp Director Qualifications: must be at least 25 years of age, and have at least two seasons of administrative or supervisory experience in camp activities. Health Supervisor (physician, registered nurse or licensed vocational nurse) employed full time

		Camp Association or 2) A description of operating procedures that addresses areas including supervisor qualifications and staff skill verification criteria.	will verify that all counselors have been trained in first aid and CPR.
Child Day Care Facility Child Day Care Center; Family Child Care Home	Health and Safety Code §§ 1596.90 – 1597.621 As appropriate, a business license as required by the local jurisdiction where the business is located.	Child Day Care Center: Title 22 CCR, §§101151-101239.2 Family Child Care Home: Title 22 CCR §§102351.1-102424	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.

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	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Licensed Community Care	Department of Social Services – Community Care Licensing Division (DSS-CCLD) and	Annually

Facilities	regional centers	

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

☑	Participant-directed	☐	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title: **Non-Medical Transportation (Participant Directed)**

Service Definition (Scope)*:*

Service offered in order to enable individuals to gain access to 1915(i) and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined in 42 CFR 440.170(a) (if applicable), and shall not replace them.

Transportation services shall be offered in accordance with the individual's plan of care and shall include transportation aides and such other assistance as is necessary to assure the safe transport of the recipient. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

A regional center may offer vouchers to family members or adult consumers to allow the families and consumers to procure their own transportation services.

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):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Individual Transportation Provider	Valid California driver's license As appropriate, a business license as required by the local jurisdiction	N/A	Welfare and Institutions Code Section 4648.3

	where the business 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):*
All Transportation Providers	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	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 for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title: **Skilled Nursing (Participant Directed)**

Service Definition (Scope)*:*

Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Skilled Nursing services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

A regional center may offer vouchers to family members or adult consumers to allow the families and consumers to procure their own nursing services.

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):*
	Skilled Nursing services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.
☑	Medically needy *(specify limits):*
	Skilled Nursing services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Registered Nurse (RN)	Business and Professions Code, §§ 2725-2742 Title 22, CCR, § 51067 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	N/A
Licensed Vocational Nurse (LVN)	Business and Professions Code, §§ 2859-2873.7 Title 22, CCR, § 51069 As appropriate, a business license as required by the local jurisdiction where the business is located.		N/A

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 Skilled Nursing Providers	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

	qualifications and duty statements; and service design.	
Registered Nurse	Board of Registered Nursing, Licensing and regional centers	Every two years
Licensed Vocational Nurse	Board of Vocational Nursing and Psychiatric Technicians, Licensing and regional centers	Every two years

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: **Financial Management Services**

Service Definition (Scope)*:*

Financial Management Services (FMS) are designed to serve as a fiscal intermediary that performs financial transactions (paying for goods and services and/or processing payroll for adult consumers' or their families' workers included in the IPP) on behalf of the consumer. FMS is an important safeguard because it ensures that consumers are in compliance with Federal and state tax, labor, workers' compensation insurance and Medicaid regulations. The term "Financial Management Services" or "FMS" is used to distinguish this important participant direction support from the activities that are performed by intermediary organizations that function as Medicaid fiscal agents.

All FMS services shall:

1. Assist the family member or adult consumer in verifying worker citizenship status.
2. Collect and process timesheets of workers.
3. Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance.
4. Track, prepare and distribute reports (e.g., expenditure) to appropriate individual(s)/entities.
5. Maintain all source documentation related to the authorized service(s) and expenditures.
6. Maintain a separate accounting for each participant's participant-directed funds.

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):*
Financial Management Services Provider	Business license, as appropriate		

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 FMS providers	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	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):*
	☐	**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):
	☐	**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):*
	☐	**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. (S*elect 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):*
	Participants who receive respite, community-based training services, skilled nursing or transportation have the opportunity to direct those services.

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):*

For those participants who receive respite, community-based training services, skilled nursing or transportation identified as a need in their IPP, the opportunity to self-direct those services will be offered at the time of the IPP development. In support of personal control over the supports and services, a voucher payment method is offered for these services. This is an option that may be selected instead of services provided by staff hired by an authorized agency through the regional center. Voucher services empower families, or the consumer, by giving them direct control over how and when the services are provided and will enable closer scrutiny of the quality of those services. For those selecting to self-direct the indicated services, FMS will be offered to provide assistance with selected administrative functions required in self-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
Respite	☑	☐
Community-Based Training Services	☑	☐
Skilled Nursing	☑	☐
Transportation	☑	☐

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

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
◉	Financial Management is furnished as a covered service entitled "Financial Management Service" as described in this amendment.

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):*

Participants are able to switch to non-participant directed services at any time. A planning team meeting is held to update the IPP, and the case manager facilitates the transition and assures no break in service. The state does not involuntarily terminate participant direction.

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.	1. DDS and DHCS	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	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. All recipients' IPPs reviewed at least annually and modified as needed based on each individual's needs.	2. Regional centers	2. Documentation in each individual's record of an (at least) annual IPP review or completion of a new IPP.		2. Annually

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
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 staff qualifications.		1. Upon application for vendorization and ongoing thereafter through 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	3.a DSS-CCLD	3.a Facilities	3.a Yes. Evaluation	3.a Annually

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
	Facilities licensed by DSS-CCLD.		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.	reports identify any deficiencies identified.	
		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	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

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
			provider's service design. IPPs.		
	4. Commission on Accreditation of Rehabilitation Facilities (CARF) process for supported employment and pre-vocational programs.	4. CARF	4. Accreditation reports and conformance of quality reports.		4. Within four years initially, then every one to three years.
	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.	DHCS	1. Results (described in "service plan" requirement above) of sample IPP reviews.		1. Biennially
	2. Review and approve required		2. Documentation of report approval		2. As required

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
	reports. 3. Review, negotiate and approve amendment requests for the interagency agreement (IA). 4. Review 1915(i) related policies, procedures, and regulations that are developed by and received from DDS. 5. DHCS, along with DDS and DSS-CCLD, conduct regular coordination meetings.		 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 policies. 5. Meeting minutes identify compliance issues and resolutions and activities planned to address issues.		 3. As required 4. As required 5. Quarterly

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
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 comprehensive financial	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)*
	accountability. 4. Verification of recipient eligibility for Medi-Cal 5. Invoice tracking, payment and reconciliation processes.	 4. DHCS, DDS, Regional Centers 5. DHCS	 4. Medi-Cal eligibility match, invoice reports. 5. Tracking logs verify consistency between payments and invoices.	 4. Yes.	 4. Monthly 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. 2. Review of special incident reports	1. Regional centers, DDS, DHCS 2. DDS, regional centers	1. Results (described in "service plan" requirement above) of sample IPP reviews. 2. Incident reports identify appropriate	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. 2. Yes. Reports are run from the SIR	1.Biennially 2. Regional centers review

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
	(SIRs) 3. Review and analysis of SIR data to identify trends.	 3. DDS, independent risk management contractor	follow-up is taken, including measures to prevent reoccurrence if 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.	database system to identify issues requiring further analysis and follow-up. 3. Yes. DDS and risk management contractor reports.	all SIRs daily. DDS reviews a sample of SIRs daily. 3. On-going
Describe the process(es) for remediation and systems improvement.	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				

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
	personal goals. • Service plans are reviewed at least annually and updated/revised when warranted by changes in the participant's needs. • Services are delivered in the type, scope, amount, duration, and frequency in accordance with the service plan. • Participants are afforded choice of qualified providers. 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. 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).				

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
	• 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 establishes qualifications for providers. 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.				

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
	Data collected (discovery) to determine if expectations are met includes: • As part of the established biennial DDS/DHCS oversight activities, on-site monitoring of service providers 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 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. 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				

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
	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 approves Section 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 Section 1915(i)				

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
	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.				

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
	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 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**				

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
	Performance expectations (design) in this area include: • Service plans must address all participants' assessed needs (including health and safety risk factors) and personal goals. • 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				

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
	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 established biennial DDS/DHCS monitoring activities, 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.				

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
	• 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*):

See attachment 4.19-B for descriptions of the rate setting methodologies for the services identified below.

☑	Community-Based Training Services
☑	Respite
☑	Non-Medical Transportation
☑	Skilled Nursing
☑	Financial Management Services

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).

1915(i) HCBS State Plan Services
Administration and Operation

1. Program Title (*optional*): California 1915(i) HCBS State Plan Participant-Directed 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):

This 1915(i) SPA employs an Organized Health Care Delivery System (OHCDS) arrangement. The Department of Developmental Services (DDS) is the OHCDS.

DDS Meets the Regulatory Definition of an OHCDS. Federal Medicaid regulations define an OHCDS as "a public or private organization for delivering health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization." 42 C.F.R. § 447.10(b). The term OHCDS is "open to interpretations broad enough to apply to systems which are not prepaid organizations." See State Medicaid Directors dated December 23, 1993. An OHCDS "must provide at least one service directly (utilizing its own employees, rather than contractors)." *Id.* "So long as the entity continues to furnish at least one service itself, it may contract with other qualified providers to furnish Medicaid covered services." *Id.*

There are adequate safeguards to ensure that OHCDS subcontractors possess the required qualifications and meet applicable Medicaid requirements e.g. maintenance of necessary documentation for the services furnished. . Under state law, regional centers are responsible for ensuring that providers meet these qualifications.

The OHCDS arrangements preserve participant free choice of providers. Free choice of providers is a hallmark of the California system. Recipients of 1915(i) services select their providers through the person centered planning process orchestrated by the regional centers, which culminates in the development of an individual program plan (signed by the beneficiary) delineating the services to be provided and the individual's choice of provider of such service(s). If an individual's choice of provider is not vendorized, they must go through the regional center vendorization process to ensure that they meet all necessary qualifications. If a provider meets the qualifications, the regional center must accept them as a vendored provider in the OHCDS.

1915(i) providers are not required to contract with an OHCDS in order to furnish services to participants. Although the open nature of the OHCDS means that virtually all providers will be part of the OHCDS, in the event a provider does not want to affiliate with the OHCDS and regional center, they may go directly to the Department of Health Care Services to execute a provider agreement. However, under state law, the process for qualifying a vendor to provide home-and-community based services to an individual with developmental disabilities is through the regional center.

The OHCDS arrangement provides for appropriate financial accountability safeguards. According to the State Medicaid Manual, when utilizing an OHCDS to provide waiver services, payment is made directly to the OHCDS and the OHCDS reimburses the subcontractors. Providers of 1915(i) SPA services submit claims to the regional center for services delivered to the beneficiary, pursuant to the individual program plan. The regional center reviews the claim (units of service, rate, etc), pays legitimate claims, and submits the claim of payment to DDS as the OHCDS. The OHCDS reimburses the regional center for the actual cost of the service, certifies the expenditures and submits a claim for the federal financial participation to the Department of Health Care Services. DDS does not "add on" to the actual costs of services incurred by and reimbursed to the regional centers.

The costs for administrative activities are not billed as part of the OHCDS payment and are claimed separately at the appropriate administrative rate.

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	1/1/2012	9/30/2012	4,000
Year 2	10/1/2012	9/30/2013	4,200
Year 3			
Year 4			
Year 5			

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):*

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; 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.

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 as follows:

Welfare and Institutions Code 4512. *As used in this division:*
(a) "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature…
(l) "Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:
(1) Self-care.
(2) Receptive and expressive language.
(3) Learning.
(4) Mobility.
(5) Self-direction.
(6) Capacity for independent living.
(7) Economic self-sufficiency.

Title 17, CCR, §54000. Developmental Disability.
(a) "Developmental Disability" means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.
(b) The Developmental Disability shall:
(1) Originate before age eighteen;
(2) Be likely to continue indefinitely;
(3) Constitute a substantial disability for the individual as defined in the article.
(c) Developmental Disability shall not include handicapping conditions that are:
(1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.
(2) Solely learning disabilities. A learning disability is a condition which manifests as a significant

discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.
(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation.

Title 17, CCR, §54001. Substantial Disability.
(a)"Substantial disability" means:
(1) 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; and
(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:
(A) Receptive and expressive language;
(B) Learning;
(C) Self-care:
(D) Mobility:
(E) Self-direction;
(F) Capacity for independent living;
(G) Economic self-sufficiency.
(b) The assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines and shall include consideration of similar qualification appraisals performed by other interdisciplinary bodies of the Department serving the potential client. The group shall include as a minimum a program coordinator, a physician, and a psychologist.
(c) The Regional Center professional group shall consult the potential client, parents, guardians/conservators, educators, advocates, and other client representatives to the extent that they are willing and available to participate in its deliberations and to the extent that the appropriate consent is obtained.

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 Among 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 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,	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, 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	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 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.	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
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; 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.	decubiti; • Administration of medical gases		

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. Private or semi-private bedrooms shared by no more than two persons with personal décor. The choice of residential settings, including making decisions regarding sharing a bedroom, is made during the person-centered planning process.

2. Private or semi-private bathrooms. The residence must have enough bathroom space to ensure residents' privacy for personal hygiene, dressing, etc.

3. Common living areas or shared common space for interaction between residents, and residents and their guests.

4. Residents must have access to a kitchen area at all times.

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

6. Services which meet the needs of each resident.

7. Assurance of residents rights: a) to be treated with respect; b) choose and wear their own clothes; c) have private space to store personal items; d) have private space to visit with friends and family; e) use the telephone with privacy; f) choose how and with whom to spend free time; and h) have opportunities to take part in community activities of their choice.

Residential settings that contain multiple independent living units (e.g. apartments) are considered home-like settings for the purposes of 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 services/supports;
   - 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):*

   The service plan, commonly referred to as the individual program plan (IPP), is prepared jointly by the planning team, which at minimum includes the individual or, as appropriate their parents, legal guardian or conservator, or authorized representative and a representative from the regional center. When invited by the individual, others may join the planning team.

The IPP is developed through a person-centered process of individualized needs determination with the opportunity for active participation by the individual/representative in the plan development and takes into account the individual's needs and preferences. Person-centered planning is an approach to determining, planning for, and working toward the preferred future of the individual and her or his family. Decisions regarding the individual's goals, services and supports included in the IPP are made by agreement of the planning team.

a) *the supports and information made available* –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* – As noted above, 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/parent/representative, 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. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*			
Service Title:	**Community-Based Training Service**		
Service Definition (Scope)*:*			
Community-based training service is a participant-directed service that allows recipients the opportunity to customize day services to meet their individualized needs. As determined by the person-centered individual program planning process, the service may include opportunities and assistance to: further the development or maintenance of employment and volunteer activities; pursue post secondary education; and increase recipients' ability to lead integrated and inclusive lives.			
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):*		
	Community-based training services are limited to a maximum of 150 hours per quarter.		
☑	Medically needy *(specify limits):*		
	Community-based training services are limited to a maximum of 150 hours per quarter.		
Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Community-Based Training Provider	As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Providers of community-based training service shall be an adult who possesses the skill, training, and experience necessary to provide services in accordance with the individual program plan.

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):*
Community-Based Training Provider	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title	Verified upon application for vendorization and ongoing thereafter

	17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	through oversight and monitoring activities.

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

☑	Participant-directed	☐	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title: **Respite Care (Participant Directed)**

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 temporary absence of family members;
3. Temporarily 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 may only be provided when the care and supervision needs of a consumer exceed that of a person of the same age without developmental disabilities.

Respite also includes the following subcomponent:

Family Support Respite – Regularly provided care and supervision of children, for periods of less than 24 hours per day, while the parents/primary non-paid caregiver are out of the home.

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 may be provided in the following locations:

- Private residence
- Adult Day Care Facility
- Child Day Care Facility
- Licensed Preschool

A regional center may offer vouchers to family members or adult consumers to allow the families and consumers to procure their own respite services.

Respite services do not duplicate services provided under the Individuals with Disabilities Education Act (IDEA) of 2004.

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):*

A consumer may receive up to 21 days of out-of-home respite services in a fiscal year, and up to 90 hours of in-home respite in a quarter unless it is demonstrated that the intensity of the consumer's care and supervision needs are such that additional respite is necessary to maintain the consumer in the family home, or there is an extraordinary event that impacts the family member's ability to meet the care and supervision needs of the consumer. These limits do not apply to family support respite.

☑ Medically needy *(specify limits):*

A consumer may receive up to 21 days of out-of-home respite services in a fiscal year, and up to 90 hours of in-home respite in a quarter unless it is demonstrated that the intensity of the consumer's care and supervision needs are such that additional respite is necessary to maintain the consumer in the family home, or there is an extraordinary event that impacts the family member's ability to meet the care and supervision needs of the consumer. These limits do not apply to family support respite.

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. As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	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.
Adult Day Care Facility	Health and Safety Code §§ 1500 - 1567.8 As appropriate, a business license as	N/A	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

	required by the local jurisdiction where the business is located.		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.
Camping Services	As appropriate, a business license as required by the local jurisdiction where the business is located.	The camp submits to the local health officer either 1) Verification that the camp is accredited by the American	Camp Director Qualifications: must be at least 25 years of age, and have at least two seasons of administrative or supervisory experience in camp activities. Health Supervisor (physician, registered nurse or licensed vocational nurse) employed full time

		Camp Association or 2) A description of operating procedures that addresses areas including supervisor qualifications and staff skill verification criteria.	will verify that all counselors have been trained in first aid and CPR.
Child Day Care Facility Child Day Care Center; Family Child Care Home	Health and Safety Code §§ 1596.90 – 1597.621 As appropriate, a business license as required by the local jurisdiction where the business is located.	Child Day Care Center: Title 22 CCR, §§101151-101239.2 Family Child Care Home: Title 22 CCR §§102351.1-102424	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.

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	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.
Licensed Community Care	Department of Social Services – Community Care Licensing Division (DSS-CCLD) and	Annually

Facilities	regional centers	

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

☑	Participant-directed	☐	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title: **Non-Medical Transportation (Participant Directed)**

Service Definition (Scope)*:*

Service offered in order to enable individuals to gain access to 1915(i) and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined in 42 CFR 440.170(a) (if applicable), and shall not replace them.

Transportation services shall be offered in accordance with the individual's plan of care and shall include transportation aides and such other assistance as is necessary to assure the safe transport of the recipient. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

A regional center may offer vouchers to family members or adult consumers to allow the families and consumers to procure their own transportation services.

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):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Individual Transportation Provider	Valid California driver's license As appropriate, a business license as required by the local jurisdiction	N/A	Welfare and Institutions Code Section 4648.3

	where the business 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):*
All Transportation Providers	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	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 for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title: **Skilled Nursing (Participant Directed)**

Service Definition (Scope)*:*

Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Skilled Nursing services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

A regional center may offer vouchers to family members or adult consumers to allow the families and consumers to procure their own nursing services.

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):*
	Skilled Nursing services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.
☑	Medically needy *(specify limits):*
	Skilled Nursing services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Registered Nurse (RN)	Business and Professions Code, §§ 2725-2742 Title 22, CCR, § 51067 As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	N/A
Licensed Vocational Nurse (LVN)	Business and Professions Code, §§ 2859-2873.7 Title 22, CCR, § 51069 As appropriate, a business license as required by the local jurisdiction where the business is located.		N/A

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 Skilled Nursing Providers	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff	Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

	qualifications and duty statements; and service design.	
Registered Nurse	Board of Registered Nursing, Licensing and regional centers	Every two years
Licensed Vocational Nurse	Board of Vocational Nursing and Psychiatric Technicians, Licensing and regional centers	Every two years

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: **Financial Management Services**

Service Definition (Scope)*:*

Financial Management Services (FMS) are designed to serve as a fiscal intermediary that performs financial transactions (paying for goods and services and/or processing payroll for adult consumers' or their families' workers included in the IPP) on behalf of the consumer. FMS is an important safeguard because it ensures that consumers are in compliance with Federal and state tax, labor, workers' compensation insurance and Medicaid regulations. The term "Financial Management Services" or "FMS" is used to distinguish this important participant direction support from the activities that are performed by intermediary organizations that function as Medicaid fiscal agents.

All FMS services shall:

1. Assist the family member or adult consumer in verifying worker citizenship status.
2. Collect and process timesheets of workers.
3. Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance.
4. Track, prepare and distribute reports (e.g., expenditure) to appropriate individual(s)/entities.
5. Maintain all source documentation related to the authorized service(s) and expenditures.
6. Maintain a separate accounting for each participant's participant-directed funds.

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):*
Financial Management Services Provider	Business license, as appropriate		

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 FMS providers	Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.	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):*
	☐	**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):
	☐	**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):*
	☐	**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):*
	Participants who receive respite, community-based training services, skilled nursing or transportation have the opportunity to direct those services.

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):*

For those participants who receive respite, community-based training services, skilled nursing or transportation identified as a need in their IPP, the opportunity to self-direct those services will be offered at the time of the IPP development. In support of personal control over the supports and services, a voucher payment method is offered for these services. This is an option that may be selected instead of services provided by staff hired by an authorized agency through the regional center. Voucher services empower families, or the consumer, by giving them direct control over how and when the services are provided and will enable closer scrutiny of the quality of those services. For those selecting to self-direct the indicated services, FMS will be offered to provide assistance with selected administrative functions required in self-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
Respite	☑	☐
Community-Based Training Services	☑	☐
Skilled Nursing	☑	☐
Transportation	☑	☐

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

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
◉	Financial Management is furnished as a covered service entitled "Financial Management Service" as described in this amendment.

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):*

Participants are able to switch to non-participant directed services at any time. A planning team meeting is held to update the IPP, and the case manager facilitates the transition and assures no break in service. The state does not involuntarily terminate participant direction.

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.	1. DDS and DHCS	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	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. All recipients' IPPs reviewed at least annually and modified as needed based on each individual's needs.	2. Regional centers	2. Documentation in each individual's record of an (at least) annual IPP review or completion of a new IPP.		2. Annually

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
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 staff qualifications.		1. Upon application for vendorization and ongoing thereafter through 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	3.a DSS-CCLD	3.a Facilities	3.a Yes. Evaluation	3.a Annually

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
	Facilities licensed by DSS-CCLD.		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.	reports identify any deficiencies identified.	
		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	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

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
			provider's service design. IPPs.		
	4. Commission on Accreditation of Rehabilitation Facilities (CARF) process for supported employment and pre-vocational programs.	4. CARF	4. Accreditation reports and conformance of quality reports.		4. Within four years initially, then every one to three years.
	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.	DHCS	1. Results (described in "service plan" requirement above) of sample IPP reviews.		1. Biennially
	2. Review and approve required		2. Documentation of report approval		2. As required

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
	reports. 3. Review, negotiate and approve amendment requests for the interagency agreement (IA). 4. Review 1915(i) related policies, procedures, and regulations that are developed by and received from DDS. 5. DHCS, along with DDS and DSS-CCLD, conduct regular coordination meetings.		 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 policies. 5. Meeting minutes identify compliance issues and resolutions and activities planned to address issues.		 3. As required 4. As required 5. Quarterly

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
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 comprehensive financial	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)*
	accountability. 4. Verification of recipient eligibility for Medi-Cal 5. Invoice tracking, payment and reconciliation processes.	 4. DHCS, DDS, Regional Centers 5. DHCS	 4. Medi-Cal eligibility match, invoice reports. 5. Tracking logs verify consistency between payments and invoices.	 4. Yes.	 4. Monthly 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. 2. Review of special incident reports	1. Regional centers, DDS, DHCS 2. DDS, regional centers	1. Results (described in "service plan" requirement above) of sample IPP reviews. 2. Incident reports identify appropriate	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. 2. Yes. Reports are run from the SIR	1.Biennially 2. Regional centers review

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
	(SIRs) 3. Review and analysis of SIR data to identify trends.	 3. DDS, independent risk management contractor	follow-up is taken, including measures to prevent reoccurrence if 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.	database system to identify issues requiring further analysis and follow-up. 3. Yes. DDS and risk management contractor reports.	all SIRs daily. DDS reviews a sample of SIRs daily. 3. On-going
Describe the process(es) for remediation and systems improvement.	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				

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
	personal goals. • Service plans are reviewed at least annually and updated/revised when warranted by changes in the participant's needs. • Services are delivered in the type, scope, amount, duration, and frequency in accordance with the service plan. • Participants are afforded choice of qualified providers. 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. 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).				

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
	• 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 establishes qualifications for providers. 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.			

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
	Data collected (discovery) to determine if expectations are met includes: • As part of the established biennial DDS/DHCS oversight activities, on-site monitoring of service providers 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 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. 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				

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
	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 approves Section 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 Section 1915(i)				

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
	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.				

Requirement	Monitoring Activity *(What)*	Monitoring Responsibilities *(Who)*	Evidence *(Data Elements)*	Management Reports *(Yes/No)*	Frequency *(Mos/Yrs)*
	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 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**				

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
	Performance expectations (design) in this area include: • Service plans must address all participants' assessed needs (including health and safety risk factors) and personal goals. • 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				

Requirement	Monitoring Activity (What)	Monitoring Responsibilities (Who)	Evidence (Data Elements)	Management Reports (Yes/No)	Frequency (Mos/Yrs)
	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 established biennial DDS/DHCS monitoring activities, 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.				

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
	• 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*):

See attachment 4.19-B for descriptions of the rate setting methodologies for the services identified below.

☑	Community-Based Training Services
☑	Respite
☑	Non-Medical Transportation
☑	Skilled Nursing
☑	Financial Management Services

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
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

SEP 25 2012

Toby Douglas, Director
California Department of Health Care Services
1501 Capitol Avenue, 6th Floor, MS 0000
Sacramento, CA 95814

Dear Mr. Douglas:

We have reviewed the proposed State Plan Amendment (SPA) 12-020, submitted to the Centers for Medicare and Medicaid Services (CMS) on June 29, 2012. This SPA proposes to add self-direction to the Section 1915(i) home and community-based services for individuals with developmental disabilities that do not have an institutional level of care. This SPA proposes to amend pages currently under review in SPA 09-023 and SPA 11-041.

Our review has indicated that the proposed SPA is not approvable as currently submitted. Before we can continue processing this amendment we need additional or clarifying information. Therefore, we are issuing the following request for additional information (RAI) pursuant to Section 1915(f)(2) of the Act.

General

1. Please clarify whether SPA 12-020 will amend SPA 09-023 or be a stand-alone SPA. If the former, please only submit the pages that will be amended with the RAI response.

2. The page numbers of the submitted pages will need to be revised once 09-023 is approved.

3. Please explain how the State computed the fiscal impact for Box 7 of the Form HCFA-179:

   FFY 12 $5,300,000
   FFY 13 $6,800,000

4. Please provide documentation to demonstrate that the State complied with the public notice requirements set forth in 42 CFR 447.205.

Coverage

5. Page 127, Person-Centered Planning, #5 – Please include a description about the information and support provided to consumers during the Individualized Program Plan (IPP) process about self-direction options.

6. Service Definitions – Please revise the voucher statement in each service definition to focus on the consumer and families in support of the consumer.

7. Page 139, Participant-Direction of Services, #2 – Please describe how consumers and their families will be informed of the benefits and liabilities of self-direction.

Reimbursement

8. Page 76, Attachment 4.19-B, Reimbursement methodology for Community-Based Training Services – The payment methodology describes that the Maximum Rate for this service is set at $13.47. Please explain whether providers will receive a rate other than $13.47? If so, how is this rate determined? Can rates range anywhere from $1 to $13.47?

9. Page 76, Attachment 4.19-B, Respite Care:
   a. Please clarify which providers are classified as family support respite and reimbursed by the Usual and Customary Rate (UCR) methodology or Median Rate Methodology.
   b. Please confirm that the Median Rate described in this proposed SPA is based on the same median rate schedule that State submitted for SPA 09-023. If the rate is based on a different median rate schedule, please provide a copy.

10. Page 77, Attachment 4.19-B, Non-Medical Transportation:
    a. The payment methodology describes that the Maximum rate paid to individual transportation provider is established as the travel rate paid by the regional center to its own employees. Please explain whether providers will receive a rate other than the rate paid to regional center employees? If so, how is this rate determined? Can rates range anywhere from $1 up to rate paid to regional center employee?
    b. Please explain how the rate is developed for regional center employees. What are the cost components included in the rate? Is there a range for these rates? Where are the rates published for providers?

11. Page 77, Attachment 4.19-B, Skilled Nursing – Please provide a web link to where the SMA for skilled nursing is published.

12. Page 78, Attachment 4.19-B, Financial Management Services – The payment methodology describes that "A rate not to exceed a maximum of $45 per consumer per month for one

participant-directed services." Please clarify whether providers can receive a rate range from $1 to $45. If so, please explain how the rate is determined.

13. Respite, Skilled Nursing and Non-Medical Transportation services are provided through self-direction and non-self-direction delivery models. Please explain if there is a process to prevent duplicate payment when reimbursements are made between two delivery models.

14. Please provide a flowchart of the self-direction payment process for the services in this SPA that includes the funding and claiming process.

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 Section 1915(f) of the Social Security Act (added by PL 97-35). This has the effect of stopping the 90-day clock with respect to CMS taking further action on this State Plan submittal. A new 90-day clock will begin when we receive your official response to this request for additional information.

In accordance with our guidelines to the State Medicaid Directors dated January 2, 2001, if the State does not respond to our request for additional information or communicate an alternate action plan within 90 days from the date of this letter, we will initiate disapproval action on the amendment. Thank you in advance for your continued cooperation in processing this SPA. If you have any questions, please contact Cynthia Nanes at (415) 744-2977 or via email at Cynthia.Nanes@cms.hhs.gov.

Sincerely,

for

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

cc: Mark Helmar, Department of Health Care Services
Jim Knight, Department of Developmental Services
Michele MacKenzie, Centers for Medicare and Medicaid Services
Kristin Dillon, Centers for Medicare and Medicaid Services