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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

December 20, 2018

Mr. Dzung Hoang
Acting Associate Regional IX Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

State Plan Amendment 18-0054

Dear Mr. Hoang,

The California Department of Health Care Services (DHCS) is pleased to submit State Plan Amendment (SPA) 18-0054 to the Centers for Medicare and Medicaid Services (CMS). SPA 18-0054 requests to amend SPA 16-016 and SPA 18-0023 to add Community Crisis Homes (CCH) as a provider type under Behavioral Intervention Services, adds categorically and medically needy limits, and adds the associated rate methodology.

DHCS delegated public notice and input responsibilities to the administering agency, the California Department of Developmental Services (DDS). Enclosed you will find SPA 18-0054 Attachment 3.1-i and Attachment 4.19B pages and a complete public notice.

If you have any questions please contact Ms. Evelyn Schaeffer, Chief, Integrated Systems of Care Division, at (916) 713-8386, or by email at Evelyn.Schaeffer@dhcs.ca.gov.

ORIGINAL SIGNED

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: http://www.dhcs.ca.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18-0054

2. STATE: CA

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: October 2, 2018

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
1915i of the Social Security Act

7. FEDERAL BUDGET IMPACT
a. FFY 2018 - 19 $ 1,219,000
b. FFY 2019 - 20 $ 2,604,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i pages 3, 32, 38
Attachment 4.19B pages 75, 75a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i pages 3, 32, 38
Attachment 4.19B page 75

10. SUBJECT OF AMENDMENT
Added Community Crisis Homes as a new provider type under Behavioral Intervention 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

ORIGNAL SIGNED

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

15. DATE SUBMITTED
December 20, 2018

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
For Box 11 "OTHER, As Specified" : Please note: The Governor's Office does not wish to review the State Plan Amendment.

Instructions on Back

State Plan Under Title XIX of the Social Security Act

STATE/TERRITORY: CALIFORNIA

Associate Behavior Analyst	No state licensing category. As appropriate, a business license as required by the local jurisdiction where the business is located.	Certification by the national Behavior Analyst Certification Board	Works under the direct supervision of a Behavior Analyst or Behavior Management Consultant.
Behavioral Technician / Paraprofessional	No state licensing category As appropriate, a business license as required by the local jurisdiction where the business is located.	N/A	Works under the direct supervision of a Behavior Analyst or Behavior Management Consultant. (1) Has a High School Diploma or the equivalent, has completed 30 hours of competency-based training designed by a certified behavior analyst, and has six months experience working with persons with developmental disabilities; or (2) Possesses an Associate's Degree in either a human, social, or educational services discipline, or a degree or certification related to behavior management, from an accredited community college or educational institution, and has six months experience working with persons with developmental disabilities.
Community Crisis Homes	Licensed Adult Residential Facility or group home by the Department of Social Services pursuant to Health and Safety Code §§ 1567.80 - 1567.87 As appropriate, a business license as required by the local jurisdiction where the business is located.	Certified by the Department of Developmental Services pursuant to WIC 4698	In addition to the requirements in Title 22, CCR, §§85000-85092, requirements from Title 17, CCR, §§59004 - 59005 also apply.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
All Habilitation – Behavioral Intervention Services 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.

evidence-based, positive approaches. Behavioral intervention services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Services may be provided to family members if they are for the benefit of the recipient. Services for family members may include training and instruction about treatment regimens and risk management strategies to enable the family to support the recipient.

The participation of parent(s) of minor children is critical to the success of a behavioral intervention plan. The person-centered planning team determines the extent of participation necessary to meet the individual's needs. "Participation" includes the following meanings: Completion of group instruction on the basics of behavior intervention; Implementation of intervention strategies, according to the intervention plan; If needed, collection of data on behavioral strategies and submission of that data to the provider for incorporation into progress reports; Participation in any needed clinical meetings; provision of suggested nominal behavior modification materials or community involvement if a reward system is used. If the absence of sufficient participation prevents successful implementation of the behavioral plan, other services will be provided to meet the individual's identified needs.

(1) "Intensive behavioral intervention" means any form of applied behavioral analysis (ABA) based treatment (see #2 below) that is comprehensive, designed to address all domains of functioning, and provided in multiple settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.
(2) "Applied behavioral analysis based treatment" means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

Behavioral Habilitation services do not include services otherwise available to the person under the Individuals with Disabilities Education Act or the Rehabilitation Act of 1973.

This service in the 1915(i) state plan benefit is only provided to individuals age 21 and over. All medically necessary Habilitation Behavior Intervention Services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

Categorically needy *(specify limits):*

Consumers are limited to 18 months in a community crisis home. Any additional day(s) must be approved by the Department and reviewed monthly thereafter.

Medically needy *(specify limits):*

Consumers are limited to 18 months in a community crisis home. Any additional day(s) must be approved by the Department and reviewed monthly thereafter.

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Crisis Team-Evaluation and Behavioral Intervention	Licensed in accordance with Business and Professions	Certified as appropriate to the skilled professions staff	Program utilizes licensed and/or certified personnel as appropriate to provide develop and implement individualized crisis behavioral services plans. Specific

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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. Tribal programs applying to become Community Care Facilities are exempt from DSS licensing requirements as provided in 25 United State Code section 1647a(a).

The OHCDS arrangements preserve participant free choice of qualified providers. Free choice of qualified 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. The vendorization process is the process for identification, selection, and utilization of service providers based on the qualifications and other requirements necessary in order to provide services. The vendorization process allows regional centers to verify, prior to the provision of services to individuals, that a provider applicant meets all of the requirements and standards specified in regulations. 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.

Qualified 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 the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions 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
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

N/A

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3) DHCS Fee Schedules - As described on page 70, above. The fee schedule rates for Non-Facility-Based Behavior Intervention Services were set as of July 15, 2016 and are effective for services provided on or after that date. All rates are published at: http://files.medical.ca.gov/pubsdoco/Rates/rates_download.asp

REIMBURSEMENT METHODOLOGY FOR RESPITE CARE

There are five rate setting methodologies for Respite Services. The applicable methodology is based on whether the service is provided by an agency, individual provider or facility, type of facility, and service design.

1) Rates Set pursuant to a Cost Statement Methodology – As described on page 69, above. This methodology is used to determine the hourly rate for In-home Respite Agencies. The rate schedule, effective July 1, 2016, for this service is located at the following link: http://www.dds.ca.gov/Rates/docs/Comm_Based_Respite.pdf

2) Rates 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 $15.23 per hour. This rate is based on the current California minimum wage of $10.00 per hour, effective January 1, 2016, plus $1.17 differential (retention incentive), plus mandated employer costs of 17.28%; a 5% rate increase for respite services per Assembly Bill (AB) X2-1, effective July 1, 2016; and an 11.25% rate increase for enhancing wages and benefits for staff who spend 75% of their time providing direct services to consumers per AB X2-1, effective July 1, 2016.

3) ARM Methodology - As described on pages 71-73 above. This methodology is applicable to respite facilities that also have rates established with this methodology for "Habilitation-Community Living Assistance Services." The daily respite rate is 1/21 of the established monthly ARM rate. This includes Foster Family Agency/Certified Family Home, Foster Family Home, Small Family Home, Group Home, Adult Residential Facility, Residential Care Facility for the Elderly, Adult Residential Facility for Persons with Special Health Care Needs and Family Home Agency. If the facility does not have rate for "Habilitation-Community Living Assistance Services" using the ARM methodology, then rates are set using #5 below.

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B. Crisis Intervention Facility – The following two methodologies apply to determine the daily rates for these providers;

1) Usual and Customary Rate Methodology - As described on page 70, above**.** If the provider does not have a usual and customary rate, then rates are set using #2 below.

1) Median Rate Methodology - As described on pages 70-71, above.

2) Community Crisis Homes rate methodology - As described in California Welfare and Institutions Code section 4698 and California Code of Regulations, Title 17, section 59022, there are three components to the monthly rate for Community Crisis Homes: 1) the facility component, 2) the individualized services and supports component, and 3) the transition plan component. The allowable costs used to calculate the facility component include payroll costs of facility staff and facility related costs such as lease, facility maintenance, repairs, cable/internet, etc. The allowable costs used to calculate the individualized services and supports component include the salaries, wages, payroll taxes, and benefits of individuals providing individualized services and supports and other consumer specific program costs. The allowable costs used to calculate the transition component includes the salaries, wages, payroll taxes and benefits of direct care staff providing additional services and supports needed to support a consumer during times of transition out of the CCH. As part of the certification process for CCHs, the Department reviews the proposed facility component rate and supporting documentation for each CCH to determine if the included costs are reasonable and economical. These rates must be approved by the Department prior to the delivery of service at each CCH. Note: This is not the rate that is claimed for FFP. See Appendix I-5 for a description of the method used to isolate and exclude room and board costs from the rate for purposes of Medicaid payment.