Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☒ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☒	Medically Fragile	0		☒
	☒	Technology Dependent	0		☒
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Individuals who meet California's definition of "developmentally disabled" and who have a "substantial disability" are included in the target population of this waiver. "Developmental Disability" is defined in the California Lanterman Developmental Disabilities Services Act, Welfare and Institutions Code, §4512, as follows:

"Developmental disability" means a disability which originates before an individual attains age 18, 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 intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

"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

- Regional Center consumers who are Medi-Cal beneficiaries who meet the LOC for this waiver.

- Consumers shall only be enrolled in one 1915(c) waiver at any one time.

- Individuals under the age of 21 are eligible for the Waiver under the Acute Hospital LOC General Definition, the Subacute LOC General Definition, and the NF-A/B LOC General Definition.

Acute Hospital LOC General Definition:
Participants to be served under this waiver at the acute LOC must be currently receiving medically necessary acute LOC services and in lieu of remaining in, or being admitted to the acute hospital setting, are choosing to remain at home or transition home and continue to receive medically necessary acute LOC services as a participant enrolled in the waiver.

Subacute LOC General Definition:
Pursuant to Title 22, CCR §51124.5, or Title 22, CCR §51124.6, adults and youth under the age of 21 who are served under this waiver at the subacute LOC must be currently receiving medically necessary subacute LOC services and in lieu of remaining in, or being admitted to the subacute setting, are choosing to remain at home or transition home and continue to receive medically necessary subacute LOC services as a participant enrolled in the waiver.

NF-A/B LOC General Definition:
Participants to be served under this waiver at the NF-A/B LOC must be currently receiving medically necessary NF- A/B LOC services and in lieu of remaining in, or being admitted to the NF-A/B setting, are choosing to remain at home or transition home and continue to receive medically necessary NF-A/B LOC services as a participant enrolled in the waiver.

ICF/MR, ICF/DD-CN Definition:
Pursuant to Health and Safety Code Section (§)1250(m), waiver-designated criteria:
This population includes individuals who are medically fragile; developmentally disabled infants, children, and adults residing in developmental centers, subacute facilities, acute care facilities, ICF/DD-Ns and in their home who meet the following ICF/DD-CN criteria and choose to receive services in their home or in a community care setting:
1. Have Medi-Cal eligibility.
2. Be determined by a Regional Center to have a developmental disability as defined by Welfare and Institutions Code §4512, and eligible for special treatment programs.
3. Be enrolled in a regional center.
4. Be free of clinically active communicable diseases reportable under Title 17, CCR §2500 if choosing to receive services in a community care facility.
5. Have an HCBA Waiver Freedom of Choice (FOC) form completed and on file. This form must be completed by the

participant or conservator/legal guardian.
6. Meet the following medical necessity criteria:
A. Participant's condition has stabilized to the point that acute care is not medically necessary;
B. Participant's condition warrants the continuous availability of nursing care by a licensed nurse inclusive of nursing assessment, and interventions with documented outcomes; and,
C. Any one of the following:
i. A tracheostomy with dependence on mechanical ventilator not inclusive of CPAP or BiPAP, for the majority of the respiratory effort;
ii. A tracheostomy that requires frequent and/or PRN nursing interventions such as medication administration, suctioning, cleaning inner cannula, changing tracheostomy ties or tube care;
iii. Peritoneal dialysis;
iv. Treatment for pressure sores at stage three or greater, and other wounds requiring sterile technique;
v. Ongoing treatment for multiple health conditions, degenerative disorders, or other complex medical problems requiring skilled nursing observation, assessment and intervention to prevent acute hospital admissions, or as an alternative to the specific conditions identified in this subsection. C. i. – v.
D. Administration of at least two treatment procedures listed below:
i. Nasal-tracheal or oral-tracheal suctioning at least every eight hours and room-air mist or oxygen any part of the day;
ii. Tube feeding either continuous drip or bolus every shift;
iii. Five days per week of physical, speech or occupational therapy provided directly by or under the direct supervision of a licensed therapist, funded by the facility at no additional cost to the Medi-Cal program;
iv. Continuous or daily intravenous administration of therapeutic agents, hydration or total parenteral nutrition (TPN) via a peripheral or a central line;
v. Skin care that requires frequent (a minimum of every four hours) skilled nursing observation and intervention with substantiating documentation

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

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

◉ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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

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

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	9871
Year 2	10759
Year 3	11727
Year 4	12782
Year 5	13932

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)*

:

○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	8974
Year 2	8974
Year 3	10081
Year 4	11215
Year 5	12349

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

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

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes
Individuals Residing in a Facility, Individuals Transitioning from Similar HCBS Programs, or Youth Under the Age of 21

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Individuals Residing in a Facility, Individuals Transitioning from Similar HCBS Programs, or Youth Under the Age of 21

Purpose *(describe):*

The HCBA Waiver reserves slots for Medi-Cal eligible individuals who meet at least one of the following criteria:
1. Have been residing in a facility for more than 60 days and can be transitioned to a home or home-like setting in the community by connecting them with services and supports they require to keep them in a community setting of their choice.
2. Are Medi-Cal members transitioning from other HCBS programs because their skilled care needs and LOC can no longer be met through those programs.
3. Are under the age of 21 years, with or without Medi-Cal eligibility, who meet all of the following criteria:
   a. who have submitted a completed HCBA Waiver application, and
   b. are medically eligible for placement into the HCBA Waiver.

Describe how the amount of reserved capacity was determined:

DHCS utilized historical data on the enrollment of individuals who transitioned from institutions or similar programs, and those under the age of 21 to set the reserve capacity amount at 60 percent of total enrollment.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	2484
Year 2	3168
Year 3	3852
Year 4	4536
Year 5	5220

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

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

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

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Waiver Agencies and DHCS comply with applicable Federal and State civil rights laws. DHCS does not unlawfully discriminate on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. Waiver Agencies and DHCS do not unlawfully exclude people or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

When slots are available under the Waiver, all applicants are placed into intake processing in the order in which their applications are received by the Waiver Agency, or DHCS in areas of the state where there is no Waiver Agency (i.e., applications are processed by the Waiver Agencies or DHCS in areas where there is no Waiver Agency, on a "first come, first served" basis, with the exception of spouses and children of active duty military service members deemed eligible for the Medi-Cal program, in accordance with W&I §14132.993). An individual requesting HCBA Waiver services must work with a Waiver Agency, or DHCS in areas where there is no Waiver Agency, to submit a complete enrollment package to DHCS. If the enrollment package is not complete or additional information is needed to determine the applicant's assessed LOC, the applicant will be deferred pending receipt of current medical information supporting the individual's skilled care needs and LOC. The Waiver Agency and DHCS will identify the applicant's potential LOC based on the information provided in the application. When a Waiver slot is available the Waiver Agency, or DHCS in areas of the state without a Waiver Agency, will schedule a face-to-face meeting, or telehealth session in accordance with DHCS' telehealth policies for Medicaid State Plan services, to assess the individual for enrollment, and provide the applicant and/or legal representative/legally responsible adult with information about the HCBA Waiver.

DHCS will consider enrolling an applicant that requests HCBA Waiver services be provided while the applicant resides in an ICF/DD-CN residence based on the coordinated efforts of the DDS Regional Centers and the Waiver providers. Before DHCS considers an application from an individual residing in an ICF/DD-CN residence, the person must be enrolled in a Regional Center, determined by the Regional Center to have a developmental disability as defined by Welfare and Institutions Code §4512, be eligible for special treatment programs, and be free of clinically active communicable diseases reportable under Title 17, California Code of Regulations (CCR) §2500.

Enrollment into the HCBA Waiver is limited to the maximum number of participants served at any point during the year. Unused Waiver capacity is referred to as available "waiver slots" for purposes of establishing and maintaining a waitlist for enrollment. If and when there is a waitlist, applicants seeking to enroll in the HCBA Waiver who meet reserve capacity eligibility requirements (e.g., Individuals Residing in a Facility; Individuals Transitioning from Similar HCBS Programs; and Youth Under the Age of 21) are prioritized for intake processing so they have, and/or maintain, access to medically necessary services in the community setting of their choice.

In accordance with W&I §14132.993, if a dependent child or spouse of an active duty military service member is currently included on the Waiver's waiting list and transfers out of state with the military service member on official military orders, the dependent child or spouse shall retain their place on the waiting list for the applicable waiver program if the child or spouse subsequently reestablishes residence in this state. The dependent child's or spouse's place on the waiting list shall advance as the waiting list advances during the time they are out of the state.

Waiver applicants who do not meet reserve capacity eligibility criteria are processed and enrolled on a first come, first served basis. If there are no Waiver slots available, applicants who are assessed as potentially meeting the Waiver's LOC criteria, will be placed on the waitlist. DHCS or the Waiver Agency will send a letter confirming receipt of the complete HCBA Waiver application, and the effective date of placement on the HCBA Waiver waitlist. Waiver slots that become available when an enrolled participant loses their eligibility, or dis-enrolls from the Waiver, will be made available for the next eligible individual on the waitlist.

HCBA Waiver eligible individuals on the waitlist will be assigned available Waiver slots in the following order, and in accordance with WIC §14132.9931:
1. Individuals transitioning to the Waiver from similar HCBS programs.
2. Individuals under 21 years of age.
3. Individuals who have been residing in a health care facility for at least 60 days at the time the HCBA Waiver application is submitted to a Waiver Agency or DHCS in areas where there is no Waiver Agency .
4. Individuals residing in the community at the time of submission of the HCBA Waiver application.

If an individual is unable to accept or declines Waiver enrollment, the open Waiver slot will be offered to the next

eligible individual in the order of prioritization. DHCS will maintain the master waitlist for the HCBA Waiver, approve enrollment of applicants, and track and notify Waiver Agencies when statewide Waiver enrollment is nearing the maximum number of enrolled participants to prevent the state from exceeding the number of participants that can be served at any point in time.

California Community Transitions (CCT) Lead Organizations frequently refer individuals who have successfully transitioned from a facility to the community, and who meet the medical criteria, for enrollment in the HCBA Waiver. The HCBA Waiver program works closely with CCT, a program developed to assist Medi-Cal eligible individuals who have been residing in a nursing facility, subacute care facility, acute hospital, or an intermediate care facility for persons with developmental disabilities, for at least two months, to find services and supports that could help them live in a community setting.

Within 60 days of notification of an available Waiver slot, an individual must schedule a face-to-face evaluation, or telehealth evaluation in accordance with DHCS' telehealth policies for Medicaid State Plan services, with the Waiver Agency or DHCS to determine eligibility for enrollment. If a face-to-face or telehealth evaluation, is not scheduled within 60 days, or if Waiver services are declined when offered, a Notice of Action (NOA) will be sent to the individual and the individual will be removed from the waitlist.

Within 90 days of notification that an individual is eligible for enrollment in the HCBA Waiver, the Waiver Agency must work with the applicant and/or legal representative/legally responsible adult to identify a Waiver service provider, and provide DHCS with a primary care physician-signed POT that meets the requirements outlined in Appendix D. The Waiver Agency must work with the participant and/or legal representative/legal guardian, and circle of support to obtain a primary care physician-signed POT within 90 days, or issue a NOA to the individual identifying why their case is being closed and that they will be removed from the waitlist. The Waiver Agency may submit a new Waiver application for the individual to DHCS for approval at any time.

The 90 day time period will be extended only for individuals who have applied for Medi-Cal where special rules are being applied to determine Medi-Cal eligibility because of their pending enrollment in the HCBA Waiver. The Waiver Agency and individual must continue to actively work with a county eligibility worker, and the Waiver Agency must continue to include updates on those activities in the applicant's case notes. An applicant's and/or legal representative's failure to cooperate with the county will be a valid reason to close the pending Waiver case.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- ◉ **§1634 State**
- ○ **SSI Criteria State**
- ○ **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- ◉ **No**
- ○ **Yes**

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

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

☐ **Low income families with children as provided in §1931 of the Act**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☒ **Optional state supplement recipients**

☒ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

◉ **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☒ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Aged, blind, and disabled individuals who may be eligible in any of the following groups even though the groups themselves may not be aged blind or disabled eligibility groups: any of the mandatory or optional categorically needy programs covered under the State Plan, including parents and caretaker relatives specified at 42 CFR 435.110, pregnant women specified at 42 CFR 435.116 and children specified at 42 CFR 435.118, and any who would otherwise be eligible for SSI/SSP as provided in the Social Security Act, Section 1902(a)(10)(A)(ii)(I), including those who are eligible under section 1634(a)(c) and (d).

All other mandatory and optional groups under the Medi-Cal State Plan are included.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

◉ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

○ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☐ **A special income level equal to:**

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

○ **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount: [ ]

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage: [ ]

○ **A dollar amount which is less than 300%.**

Specify dollar amount: [ ]

○ **A percentage of the Federal poverty level**

Specify percentage: [ ]

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

◉ **The following formula is used to determine the needs allowance:**

Specify:

An amount which represents the sum of (1) the income standard used to determine eligibility and (2) any amounts of income disregarded during the Section 1902(a)(10)(A)(ii)(VI) eligibility phase.

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the

contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:

- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised

- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:

- ◉ **Other**

  Specify:

  An amount that represents the sum of (1) the income standard used to determine eligibility and (2) any amount of income disregarded during the section 1902(a)(10)(A)(ii)(VI) eligibility phase.

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ○ **The state does not establish reasonable limits.**
- ○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to

need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

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

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- (●) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

Local/Regional Non-State Entities also known as Waiver Agencies under a contract with DHCS perform LOC initial evaluations and reevaluations.

In areas where there is no Waiver Agency, DHCS performs the LOC initial evaluations and reevaluations.

- ( ) **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

An RN, licensed to practice in the State of California, will perform the initial LOC evaluation of the HCBA Waiver applicants during a face-to-face intake home/community visit, or a telehealth intake home/community visit conducted in accordance with DHCS' telehealth policies for Medicaid State Plan services.

The Waiver Agency will perform the initial evaluation of Waiver applicants' LOC based upon the documentation included in the intake packet. DHCS will review and make the final determination of applicant' LOC based on the information provided by the Waiver Agency RN during the home/community or LOC evaluation visit that is conducted in-person or via telehealth in accordance with DHCS' telehealth policies for Medicaid State Plan services. In areas where there is no Waiver Agency, DHCS will continue to perform the LOC evaluations and approve waiver services.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The criteria used for waiver LOC is determined by criteria established in Title 22, California Code of Regulations (CCR) Division 3, §51173.1, 51120, 51124, 51124.5, 51125.6, 51334 and 51335; Health and Safety Code §1250(m); as well as information submitted to support medical necessity for the services as defined in Title 22, CCR §51003.

This Waiver will serve disabled Medi-Cal members, who would, in the absence of this Waiver, and as a matter of medical necessity, pursuant to Welfare & Institutions Code §14059, otherwise require care in a health care facility providing the following types of care:

Acute Hospital LOC
The HCBA Waiver will serve Medi-Cal members who would, in the absence of this Waiver, and as a matter of medical necessity, pursuant to California Welfare and Institutions Code, §14059.5, require services only available in an acute hospital setting for at least 90 consecutive days, pursuant to CCR, Title 22, §51173.1 and meet the criteria as described in CCR, Title 22, § 51344 (a) and (b). Waiver Participants at the acute LOC must currently be receiving medically necessary acute LOC services, and choose to remain home, or to return home, to receive medically necessary acute LOC services as a participant enrolled in the Waiver, in lieu of remaining in, or being admitted to the acute hospital setting. All requests for acute hospital LOC Waiver services shall meet the criteria as described in this waiver in addition to the criteria set forth in Title 22, CCR, §51344 (a) (b) (c) and 51173.1.

For each reevaluation, the participant must continue to meet the criteria as described in the above cited CCR and W&I Code, in addition to the other criteria outlined in this Waiver application.

Subacute LOC
1. NF Subacute Care services, pursuant to Title 22, CCR, §51124.5; or
2. NF Pediatric Subacute Care services, pursuant to Title 22, CCR, §51124.6.

NF A/B LOC
This Waiver will serve Medi-Cal members who would, in the absence of this Waiver, and as a matter of medical necessity, pursuant to Welfare and Institutions Code, §14059.5, otherwise require care for 60 consecutive days or greater in an inpatient NF providing the following types of care:
1. NF Level A – Intermediate Care services pursuant to Title 22, CCR, §51120 and 51334.
2. NF Level B – Skilled Nursing Facility services pursuant to Title 22, CCR, §51124 and 51335.

For each reevaluation, the participant must continue to meet the criteria as described in the above cited CCR and W&I Codes, in addition to those criteria outlined in this waiver.

The IMS/CMR, as described in Appendix B-6,-e is used after the initial evaluation and subsequent reevaluation to document if the participant continues to meet waiver requirements. Waiver participant case records are routinely reviewed by DHCS to determine if the Waiver Agency LOC determination is correct and that the home safety evaluation is complete. The LOC determinations may be reviewed by the DHCS Medical Consultant (MC) who could be a DHCS RN, a DHCS RN Supervisor, or a physician licensed to practice in the State of California.

The State uses the same LOC criteria for participants in the Waiver as eligibility requirements for members outside of the Waiver under all institutional setting types as outlined in this Waiver and the Medi-Cal State Plan.

DHCS will review all completed applications to verify an applicant's eligibility. A complete application includes a LOC evaluation completed by the Waiver Agency. DHCS will review the initial, and periodic, LOC evaluations provided by the Waiver Agency for completeness and appropriateness. If there is a discrepancy between the LOC and medical documentation that is provided, DHCS will work with the Waiver Agency to address questions, make clarifications, and assign the appropriate LOC.

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

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

In conjunction with the NF LOC and assessments/reassessments, the CMT and DHCS use the IMS and CMR to measure the applicant's condition. The CMT and DHCS use available medical documentation as well as in-person observations and interviews to complete the IMS and CMR. The IMS and CMR include the same criteria to determine NF LOC as the State Plan. If it is determined that the applicant meets the NF LOC identified, they meet the required LOC eligibility criteria to move forward in the Waiver application process.

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

DHCS determines HCBA Waiver enrollment, and both DHCS and the Waiver Agencies authorize services based on medical necessity to maintain the applicant's health, welfare, and safety in the community setting or residence. The Waiver Agency or DHCS may assess and approve services as long as the Waiver services (e.g., nursing services provided by licensed personnel (registered nurse, licensed vocational nurse, certified home health aides), habilitation services provided by trained, supervised personnel, and case management services, etc.), are medically necessary. Medical necessity is defined as set forth in Welfare and Institutions Code §14059.5, as follows: A service is "medically necessary" or of a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

The Waiver Agency or DHCS utilizes the following procedures to determine, in advance of waiver enrollment, that the individual's health and welfare can be maintained or improved, to the extent possible, in the community:

1. When assessing an individual to determine the LOC, the Waiver Agency or DHCS reviews the available medical documentation and other pertinent information in the applicant's record (such as the existing treatment plan, progress reports, medical and psychological evaluations, and case management notes), to determine the qualifying conditions that significantly affect the applicant's ability to perform activities of daily living and/or participate in community activities.

2. The Waiver Agency or DHCS schedules a face-to-face intake visit, or telehealth session in accordance with DHCS' telehealth policies for Medicaid State Plan services, with the potential waiver participant and a comprehensive evaluation is completed. The Waiver Agency or DHCS utilizes this evaluation to determine if the applicant meets one of the HCBA Waiver LOCs. The information from the initial visit is documented in the Case Record along with medical justification to support the LOC determination and the need to receive the type, frequency, and amount of Waiver services that are currently authorized or being requested by the applicant's current primary care physician to sustain the health and safety of the applicant to return and/or remain safely in their home and community.

3. Upon the determination of the applicant's LOC and the need for services, the Waiver Agency or DHCS provides information to the applicant, and/or their legal representative/legally responsible adult and/or circle of support, on the services available through the HCBA Waiver. The CMT or HCBA Waiver Case Management provider works with the applicant, and/or their legal representative/legally responsible adult and/or circle of support, as defined below, and the applicant's current primary care physician, to identify State Plan and HCBA Waiver services that meet the applicant's medically necessary care needs as well as their individual preferences related to specific health and daily living goals.

• A participant's circle of support can include, but is not limited to: family, friends, neighbors, teachers, classmates, co-workers, community groups, faith-based groups, and anyone else the participant wants to invite to be part of their circle of support.
• The role of the circle of support is to advance the goals of a person with a disability by helping them formulate goals, provide practical advice, help identify solutions to problems, and look out for the participant's best interests. Participating as a member of the circle of support does not alter otherwise existing legal obligations, responsibilities, or authority to make decisions on behalf of the participant.
• Members of the circle of support are encouraged to assist the participant in the event their scheduled caregiver is not available. Assistance may include, but is not limited to, staying with the participant to keep them safe until a backup care provider can be arranged, contacting the CMT so they can arrange for a backup caregiver, and providing unlicensed care, etc. Individuals who commit to participate as a member of the circle of support do so voluntarily, and do not receive payment from Medi-Cal for the support they give the participant.

4. The Waiver Agency or DHCS documents the type, frequency, and amount of waiver and State Plan services the applicant is currently receiving and/or the services the applicant's current primary care physician has ordered, and details it in the POT, which includes the MOHS. The MOHS is a planning instrument used by the applicant and/or their legal representative/legally responsible adult, circle of support, and the CMT or HCBA Case Management provider to develop a home care program that protects and sustains the applicant's health, safety, and welfare in the community. The MOHS summarizes all the waiver services and provider types available through the HCBA Waiver. The MOHS enables the applicant and/or their legal representative/legally responsible adult and/or their circle of support to select a combination of waiver and State Plan services best suited to meet their medically necessary care needs and maintain, to the extent possible, their health and safety in the community.

5. The Waiver Agency submits the completed HCBA Waiver application, Medi-Cal eligibility summary report, IMS/CMR, POT, and MOHS, also known as the Case Record, to DHCS for approval of waiver enrollment. If DHCS

determines the applicant does not meet the Waiver eligibility requirements, including medical necessity and LOC, health and safety criteria, or HCBS settings requirements, DHCS will issue a NOA denying enrollment in the HCBA Waiver.

6. Upon DHCS approval of an applicant's enrollment into the Waiver, the Waiver Agency notifies the participant and authorizes TAR submitted by HCBS providers selected to provide the medically necessary Waiver services at the type, scope, frequency, and amount described in the approved POT.

The Waiver Agency or DHCS conducts a complete LOC reevaluation of the applicant or participant's medical need for Waiver services following the reevaluation schedule described in Appendix B, Section 6.g. The LOC reevaluations are documented in the Case Record and include identification of a current primary care physician who provides the participant's specific written orders; a complete and accurate written medical record including diagnoses, history, physical assessment, treatment plan, and prognosis; and confirmation that a medical need exists for the services included in the POT.

For a complete description of the LOC criterion used to evaluate and reevaluate an applicant or participant's need for waiver services, refer to Appendix B, Section 1.b. Once the evaluation visit is completed, the Waiver Agency and DHCS use the CMR to document the individual's LOC and medically necessary care needs, including identification of caregivers and support systems; a home safety evaluation, and concerns or issues identified by the applicant or participant, their circle of support, caregivers or the Waiver Agency or DHCS. The CMR also documents plans for resolution of issues identified during the evaluation for waiver enrollment and LOC reassessments. The Waiver Agency provides a justification and recommendation to DHCS for the applicant or participant's LOC in the Case Record.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ○ **Every twelve months**
- ◉ **Other schedule**

  Specify the other schedule:

The Waiver Agency and DHCS use the HCBA Care Management Acuity Assessment Tool (Acuity Tool) to determine the periodicity of reevaluations and the intensity of the required participant case management. Information collected during the initial evaluation and subsequent reevaluations is entered into the Acuity Tool to determine a participant's level of care management acuity. HCBA Waiver participants are assigned a level of care management acuity from one to four, which is based on factors such as a participant's medical stability, compliance with the POT, issues affecting participant health and safety, and availability and adequacy of staffing to provide waiver services. The CMT, or HCBA Case Management provider in areas of the state not covered by a Waiver Agency, will conduct on-site home visits based upon the level of care management acuity, or as necessary, to assess the effectiveness of the home program in protecting and sustaining the participant's health and safety, and adherence to the POT.

Comprehensive Care Management visits/calls must be completed by the CMT on at least a monthly basis, or more frequently, based on the Waiver participant's level of care management acuity. These visits/calls are intended to determine the overall wellbeing of the Waiver participant, verify if they are receiving the appropriate services in the frequency and duration listed in their POT, they are happy with the services they are receiving, and to address any problems or concerns they may have.

Reevaluation visits are intended to reassess the participant's LOC needs and medically necessary services. All completed reevaluation documentation must be uploaded into the applicant or participant's case file within the MedCompass case file management system within the appropriate time frames. Reevaluation period requirements are as follows:

Level 1 - Participants are reevaluated at least once every 365 days. Participants are medically stable, have not recently been hospitalized for emergency care, and have no eligibility or staffing issues.

Level 2 - Participants are reevaluated more often, at least once every 270 to 365 days. Participants have minor staffing or durable medical equipment issues and maintain regular contact with the CMT or HCBA Case Management provider.

Level 3 - Participants are reevaluated at least once every 180 to 270 days. Participants may have high turnover of waiver providers, have had four or more unscheduled hospitalizations in the previous 12-month period, and/or had difficulty in obtaining the current primary care physician ordered medically-necessary services.

Level 4 - Participants are reevaluated more frequently than once every 180 days. Participants require frequent monitoring and interventions by the CMT or HCBA Case Management provider to address issues that affect their health and safety, and are at an elevated risk. The CMT or HCBA Case Management provider conducts frequent on-site visits to work with the participant and/or their legal representative/legally responsible adult(s) and/or circle of support and the HCBS waiver providers responsible for rendering waiver services when there are issues requiring a plan of correction and follow-up.

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

◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

○ **The qualifications are different.**
Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify)*:

Reevaluations of the waiver participant's LOC are conducted at a minimum of every 365 days. DHCS conducts Quality Assurance Reviews (QARs) for monitoring and ongoing compliance assurance, as required. DHCS analyzes case records, progress notes, assessment/reassessments, participants' POTs, and any other documentation pertinent to determining:
1. There is documentation supporting the LOC criteria,
2. Evaluations and reevaluations are timely, and
3. Documentation has been completed by the appropriate Waiver Agency personnel.

If DHCS identifies deficiencies in a Waiver Agency's performance in completing LOC reevaluations, DHCS issues a written report of the findings and recommendations to the Waiver Agency, including a formal written request for a Corrective Action Plan (CAP) specific to remediating the deficiencies. The Waiver Agency is required to respond to DHCS within 30 days of the date of the QAR report, and to develop a formal CAP to address any deficiencies that were identified. Upon receipt of the CAP, DHCS reviews the CAP for implementation and monitors the Waiver Agency's resolution process to assess the remediation of the deficiency(ies). Once DHCS approves the CAP for implementation, the Waiver Agency is given an opportunity to implement the developed strategy. DHCS may conduct an on-site follow-up visit to the Waiver Agency to evaluate the effectiveness of the Waiver Agency's new practice, and/or ask the Waiver Agency to submit additional records for quality assurance review. When the Waiver Agency has appropriately remediated the issue(s) addressed in the CAP, DHCS will issue an approval letter. DHCS provides technical assistance to Waiver Agencies throughout the process as needed.

In areas where there are no Waiver Agencies, DHCS generates quarterly reports from the Care Management database. The database tracks the date of last evaluation and the date when the participant requires a reevaluation. Quarterly tracking reports are distributed to DHCS Nurse Evaluators for workload planning and scheduling home visits.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The LOC evaluation and reevaluation records are maintained in a participant's electronically retrievable case record within the MedCompass Case Management System. Assigned staff with appropriate user privileges within DHCS and the Waiver Agencies have access to assigned participants' case files, including the evaluations and re-evaluations of participants' level of care.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure. provide information on the aggregated data that will enable the State to

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

Performance Measure:
 # and % of Waiver participants who received a nursing assessment completed by qualified personnel, RN, with a current license to practice in the State of California. Numerator: Number of nursing assessments completed by qualified personnel, RN, with a current license to practice in the State of California / Denominator: Total number of files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Records, Files, and Paid Claims

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: HCBA Waiver Agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

 # and % of case files with LOC (re)determinations completed in accordance with waiver LOC criteria defined in Title 22, and supported by appropriate medical documentation. Numerator: Number of case files with LOC (re)determinations completed in accordance with waiver LOC criteria defined in Title 22, and supported by appropriate medical documentation / Denominator: Total number of files reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☒ **Other** Specify: Waiver Agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

DHCS reviews case files in the MedCompass case file management system and uses the QAR process to discover/identify problems/issues within the waiver program.

MedCompass stores, but is not limited to, the following data:
• The date Waiver Agencies or DHCS receive Waiver applications;
• The date Waiver Agencies or DHCS review Waiver applications;
• The date participants are enrolled in the Waiver; and
• The next re-evaluation visit due date, based upon the level of case management acuity.

During the QAR, DHCS evaluates the timeliness and accuracy of LOC determinations based on the information documented in the participant's case file.

The Waiver Agency/CMT is responsible for the evaluation visit and DHCS maintains waiver eligibility determinations. The CMT consists of at least one RN and one Social Worker, or an individual with a Bachelor's level degree in a related field, supervised by an MSW. The Waiver Agency must submit evidence of the evaluation visit and documentation of the applicant's appropriate LOC to DHCS before the applicant is enrolled in the HCBA Waiver. DHCS determines the applicant's eligibility and validates the LOC. MedCompass includes an edit that will not allow the participant to be opened to the waiver unless the date of the evaluation visit has been entered. Open Enrollment status into the waiver is documented by entering the date the participant was approved eligible for the HCBA Waiver.

LOC reevaluations are conducted as described in Appendix B. The Waiver Agency or DHCS is responsible for the timeliness of LOC reevaluations. DHCS requires Waiver Agencies to submit QPRs, which includes an evaluation of the timeliness of the LOC reevaluations. DHCS then audits the QPR to assess Waiver Agency adherence to Waiver requirements. In the coming years, a system update will be made to the MedCompass case file management system to automatically generate the date of the next visit and track Waiver Agency compliance based upon the date of the last LOC evaluation and the participant's level of case management acuity.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The Waiver Agency submits a quarterly report that is audited by DHCS that identifies participants who have not had their LOC reevaluation completed within 60 days of the due date, and their plan or schedule for completing the overdue home visits.

DHCS is responsible for conducting annual onsite and/or electronic Waiver Agency QAR. In areas of the state where there is no Waiver Agency, DHCS conducts annual Case Record Reviews on active HCBA Waiver cases. The selected sample size for the number of case records to be reviewed is determined by using the sample size calculator located at: www.surveysystem.com/sscalc.htm. DHCS randomly selects a sample of case records with a 95% level of confidence with a 5% interval for the entire waiver population. The Waiver population includes all Waiver participants that were open to the Waiver anytime during the selected Waiver year. Using the identified sample size indicated by the Sample Size Calculator, DHCS selects the cases for review based upon the corresponding percentage of participants at each LOC.

The Waiver Agencies use a CMR when conducting the LOC evaluation to document their observations, actions, and information obtained during the participant's initial and all re-evaluation visits. The Waiver Agency documents the participant's medically necessary care needs and the justification of the LOC in the CMR and uploads the CMR to the participant's case file in MedCompass. DHCS uses the CMR criteria and regulations cited in the HCBA Waiver to verify LOC determinations.

DHCS reviews the LOC determinations during the QAR to audit a Waiver Agency's performance and to determine if they are in compliance with the HCBA Waiver. If DHCS and the Waiver Agency do not agree with the LOC determination, the CMR is reviewed by another DHCS MC. The DHCS MC's LOC determination is final and documented in the case report. Within 30 days of the review, DHCS will present an analysis of the findings to the Waiver Agency. Based upon the findings and level of compliance, the Waiver Agency will develop and implement a remediation plan within 30 days.

Remediation may include identification of individuals in the Waiver Agency or their provider network in need of remedial training, or systemic issues requiring correction, such as evaluation procedures affecting the accuracy of LOC determinations. Effectiveness of the remediation actions will be monitored by DHCS through monthly follow-up discovery activities, when necessary.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver participants and/or their legal representative/legally responsible adult(s) are informed of their right to accept or decline Waiver enrollment and Waiver services during the initial evaluation.
Information about the HCBA Waiver is provided verbally and in writing through use of the Freedom of Choice (FOC) form and Informing Notice.

A signed FOC form is required of all participants prior to waiver enrollment and before authorization of waiver services, or when declining waiver services. After initial evaluation for HCBA Waiver enrollment, the Waiver Agency or DHCS sends the participant and/or their legal representative/legally responsible adult(s) a FOC letter and form for their signature. By signing the FOC form, the participant's and/or their legal representative/legally responsible adult(s)', is acknowledging that the Waiver Agency or DHCS has described the services available under the HCBA Waiver, which are provided as an alternative to care in a licensed heath care facility. The FOC letter advises the participant and/or their legal representative/legally responsible adult(s) of their right to utilize qualified waiver service providers of their choice.

Enclosed with the FOC form and letter is the Informing Notice, which describes the roles and responsibilities of the participant, their legal representative/legally responsible adults, the Waiver Agency or DHCS, HCBS providers and the participant's current primary care physician. The Informing Notice is re-distributed whenever there is a change in the Waiver Agency, or the participant's current primary care physician.

The participant and/or their legal representative/legally responsible adult(s) are advised to return the signed and dated FOC form within five days of receipt. Waiver services are not approved for the participant until the signed FOC is received by the Waiver Agency or DHCS. If a signed FOC is not received by the Waiver Agency or DHCS within 30 days of the date the FOC was mailed to the participant, enrollment in the HCBA Waiver will be considered "Declined" and the case will be closed.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice

forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The signed FOC form is maintained in the participant's case record within the MedCompass case file management system.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

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

DHCS implements the following strategies and methods to provide meaningful access to the Waiver by Limited English Proficient persons in accordance with 68 FR 47311:

A key component of case management is conducting community outreach to expand waiver enrollment, reach populations and/or groups in the community who are institutionalized or at risk of institutionalization, and provide meaningful access to Waiver services for all persons, including those with Limited English Proficiency (LEP).

• Waiver Agencies implement strategies to recruit, retain, and promote, at all levels of the organization, a diverse staff and leadership who are representative of the demographic characteristics of the service area.
• Waiver Agencies provide effective, understandable, and respectful care in a manner compatible with their cultural health beliefs, practices and preferred language.
• DHCS requires Waiver Agencies to hire employees able to provide linguistic diversity to allow participants an opportunity for selection and participant choice.
• Participant forms required by the HCBA Waiver are available in English with taglines in required threshold languages so that participants may request translations in their preferred language.

If the need arises, DHCS will translate forms into other languages or alternative formats, upon request.